Medicare Managed Care Manual

Chapter 3 - Marketing

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10 - Introduction

(Rev. 28, 08-01-03)

This chapter explains requirements for marketing. [1]The intent of this chapter is to:

- Expedite the process for CMS' review of marketing materials;

- Conserve resources by avoiding multiple submissions/reviews of a document prior to final approval;

- Ensure consistent marketing review across the nation; and

- Enable *Medicare + Choice organizations (M+C organizations) and cost-contracting health plans (cost plans)* to develop accurate, consumer friendly, and marketing information that will assist beneficiaries in making informed health care choices.

Marketing materials, in general, *are* informational materials targeted to Medicare beneficiaries that promote the *health plan/M+C organization* or any plan offered by the *health plan/M+C organization*, or communicate or explain an M+C *or cost* plan.[2] (See 42 CFR 422.80(b).) The definition of marketing materials extends beyond the public's general concept of advertising materials to include notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership scenarios. *Health education materials are generally not under the purview of CMS marketing review. However, if such materials are used in any way to promote the M+C organization or explain benefits or plan rules, then they are considered marketing materials and must be approved before use. If there is any "commercial message" (defined previously in this section) or beneficiary notification information in a health education piece, it must be reviewed by CMS.*

General guidance regarding the marketing review process, including the process for review of materials submitted by national organizations, is provided in §20. In addition, this chapter contains two separate sections devoted to the discussion of guidelines for marketing materials. Section 30 addresses requirements for advertising or "pre-enrollment" materials, and §40 addresses requirements for beneficiary notification materials that are provided for beneficiaries currently enrolled in the plan. Materials relating to promotional activities, including health fairs and sales presentations, are also included in the general definition of marketing materials and are discussed in §50. *Guidelines for other marketing activities, including marketing value added items and services and marketing multiple lines of business, are addressed in §60.*

10.1 - HIPAA Considerations

(Rev. 20, 04-04-03)

On April 14, 2003, new Federal rules governing the privacy of health data become enforceable. The rule "Standards for Privacy of Individually Identifiable Health Information" is found at 45 CFR Part 164. Health plans/M+C organizations may use or disclose their members' protected health information as permitted by that rule. Specifically, they may use or disclose this information without beneficiary authorization for treatment, payment or health operations (as those terms are defined by the rule) and for a number of public policy purposes, such as public health and research, recognized in the rule. Health plans/M+C organizations are not required to obtain authorization from

beneficiaries prior to marketing their plan benefit packages. For additional information regarding HIPAA, go to http://www.hhs.gov/ocr/hipaa/.

20 - Marketing Review Process

(Rev. 28, 08-01-03)

Marketing review consists of:

- Pre-approval of marketing materials before they are used by the health plan/M+C organization;
- Review of on-site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits;
- Random review of actual marketing pieces as they are used in/by the media;
- *Retrospective review of marketing materials approved under the streamlined marketing review process; and*
- "For cause" review of materials and activities when complaints are made by any source.

This chapter deals primarily with the pre-approval of marketing materials. As outlined in regulations at 42 CFR 422.80(a) *and* 417.428(a)(3)*, health plans/M+C organizations* may not distribute any marketing materials or election forms or make them available to individuals eligible to elect a *plan offered by a M+C organization/cost* plan unless such materials have been submitted to CMS at least 45 days prior to distribution and CMS has not disapproved the materials. A *health plan/M+C organization* may also distribute materials before 45 days have elapsed if prior approval has been granted by CMS. There is a limited exception to this requirement for model beneficiary notices, as outlined in §40 of this chapter. Guidelines for CMS review are further described at 42 CFR 422.80(c) *for M+C organizations and 417.428(a) for cost plans*. Marketing materials, once approved, remain approved until either the material is altered by the *health plan*/M+C organization or conditions change such that the material is no longer accurate. The CMS may, at any time, require a *health plan/*M+C organization to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

Exception to the 45-day marketing review rule:

- ***M+C organization Exception:*** *When an M+C organization follows CMS model language without modification, CMS must review the material within 10 days (as opposed to the usual 45 days). The CMS must make a determination on the material within 10 days or else the marketing material is deemed approved.*

- ***Cost Plan Exception:*** *While not required by law, CMS will review materials prepared by cost plans within 10 days if they have followed CMS cost plan model language without modification. However, while CMS intends to review the cost plan marketing materials within 10 days, the cost plan must not consider the material deemed approved if 10 days pass, and it has not received approval or disapproval from CMS since, by law, 45 days must pass before the material may be deemed approved.*

To alert the CMS reviewer to the need for a 10-day review, the health plan/M+C organization must indicate on the submission that it has followed the CMS model without modification and is requesting a 10-day review.

The 10-day review period only applies when the health plan/M+C organization has followed the CMS model without modification. "Without modification" means the health plan/M+C organization used CMS model language verbatim and only used its own language in areas where we have given them license to include their own information (such as where they are asked to include their plan-specific benefits). It also means that the *health plan/M+C organization* has followed the sequence of information provided in the model in its own marketing material. In these cases, the regional office may only need to review the *health plan's/M+C organization's* language in order to make a determination on the marketing material within the 10-day time frame.

NOTE: *An organization's Evidence of Coverage (EOC)* cannot be approved until an M+C organization's Adjusted Community Rate (ACR) is approved. *If an organization submits its EOC for review early in the year (prior to ACR approval),* the Regional Office (RO) will review and approve all non-ACR-related information within the 10-day review period, and will conduct a cursory review of all ACR-related information based on the M+C organization's ACR submission. However, the Regional Office will need to disapprove the release of ACR-related marketing material within the 10-day window, since there is no basis for approving it, and indicate that the material will be approved upon approval of the ACR. The Regional Office will need to promptly review and approve these marketing materials upon approval of the ACR.

20.1 - Marketing Review Process for Multi-Region Organizations

If you are an organization that operates in more than one of CMS' Regional Offices, your marketing review approach (i.e., lead region, local regions, etc) is determined by the agreement your organization makes with CMS Multi-Region Team management.

The Multi-Region M+C organization must ensure that materials submitted are consistent with the requirements in this chapter.

In addition, the Multi-Region M+C organization must distribute final copies of its national marketing materials, within a time frame to be determined by its CMS Multi-Region team, to the lead and local ROs with a dated cover letter, which identifies the recipients.

NOTE: Although the local ROs may no longer play a part in approval of the national marketing piece, the health plan/M+C organization must send a final copy of the approved material to the local ROs for their records.

20.2 - Employer Group Marketing Review Process

(Rev. 9, 04-01-02)

Under the authority granted in §617 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, CMS has waived all M+C organizations from having to follow the requirements under 42 CFR 422.80(a) for employer group members. This means that M+C organizations need not have CMS pre-approve marketing materials prepared by M+C organizations designed for members of employer groups. (The waiver does not include waiving the requirements at 42 CFR 422.111, which outline what information must be provided to members annually and at the time of enrollment. We believe this information is critical for members to completely understand the benefits in a plan, rules for obtaining covered services, and the rights they have as members of the plan.)

The CMS will assume that M+C organizations have chosen to use this waiver unless we hear otherwise from the M+C organization. All M+C organizations will be required to send informational copies of employer group-specific marketing materials to the Regional Office/lead region within 14 days of their release/use. (Regional Offices will not be reviewing these materials; instead, they will keep them on file in the event any inquiries are received about them.)

The M+C organization assumes responsibility for the accuracy of the employer group marketing materials, including making any corrections to those materials when necessary. The M+C organization is expected to continue to follow the guidelines within this chapter when preparing its marketing materials. In the unusual circumstance of an organization knowingly releasing/distributing incorrect or false marketing materials, sanctions, and or/fines may be imposed on that organization.

20.3 – Streamlined Marketing Review Process

(Rev. 28, 08-01-03)

The CMS offers a streamlined marketing review process to M+C organizations and demonstrations for certain marketing materials in order to ensure that the materials can be available to Medicare beneficiaries in time to make decisions about their health insurance coverage. In particular, the streamlined marketing review process only applies to marketing materials developed for the Fall campaign (i.e., the Annual Notice of Change (ANOC), the Summary of Benefits (SB), and materials necessary to develop an annual enrollment period marketing package in the Fall to encourage members to join

the plan) and marketing materials developed to notify members of any mid-year benefit enhancements.

An organization may choose one of two ways to have materials reviewed and approved under the streamlined process.

Option 1: M+C organizations can obtain approval of their plan marketing materials based on submitted ACRPs.

Under this option the CMS RO will review the materials based on thesubmitted (i.e., not yet approved) ACRP information. Organizations are encouraged to begin submitting the marketing materials for review by the date that M+C organizations may submit ACRPs to CMS. If the organization follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB is 10 days prior to the date that M+C organizations may submit ACRPs to CMS.

Option 2: An M+C organization can submit materials without cost sharing/benefit information contained in the "template" material.

Under this option the RO will review the template and the organization will be responsible for inserting the accurate cost sharing/benefit information after approval is received. Organizations can submit the marketing materials for review before the date that M+C organizations may submit ACRPs to CMS, since these materials would not contain the ACRP information. If the M+C organization follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB is 10 days before the date that M+C organizations may submit ACRPs to CMS.

Regardless of which option is chosen, keep in mind the following:

- *The organization must use the "pending Federal approval" disclaimer on the materials until the ACR is approved by CMS. Once the ACR is approved, the M+C organization must remove the disclaimer.*

- *If the organization resubmits an ACRP that includes changes/corrections that affect marketing materials already approved or under review, the organization is responsible for correcting all marketing materials to reflect these ACRP changes. The material does not need another approval by CMS.*

- *Any organization that uses marketing materials containing errors (e.g., the benefit or cost sharing information differs from that in the approved ACRP) will be required to correct those materials for prospective members and send errata sheets/addenda to current members before January 1. The CMS will conduct a retrospective review of a sample of M+C plan materials and will notify the organization if corrections are necessary. The M+C organization will be expected to conduct a self review of all other marketing materials for plans not included in the sample and to issue CMS-approved correction notices as necessary.*

30 - Guidelines for Advertising Materials

(Rev. 28, 08-01-03)

This section provides guidance to health plans/M+C organizations regarding sales packages and language that may be used in pre-enrollment marketing materials. Pre-enrollment material may be defined as material that is intended primarily to attract or appeal to M+C eligible non-members, and to promote membership retention by providing general information to enrollees about the health plan. This includes all ads (print as well as radio, TV, and Internet ads) and certain other material such as sales scripts, sales presentation flyers, and direct mail pieces that contain information of interest to all potential and current enrollees of the plan.

Section 30.1 provides guidance for advertising materials which tend to make up the bulk of pre-enrollment materials. Section 30.2 provides guidance on minimum information requirements for sales packages. Section 30.3 includes a matrix describing marketing language that health plans/M+C organizations "Must Use/Can't Use/Can Use."

30.1 - Guidelines for Advertising (Pre-enrollment) Materials

(Rev. 28, 08-01-03)

These guidelines were created by identifying required language frequently omitted by health plans/M+C organizations or revised by the CMS. Acceptable language was created to meet both CMS requirements and the needs of the health plans/M+C organizations. Although use of suggested "Can Use" language is not required, its use will expedite the review process and achieve greater consistency among marketing materials. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits (SB) is required. Please also note that the language provided in the "Must Use" column of the "Must Use/Can't Use/Can Use Chart" (see §30.3 of this chapter) is required for all the marketing materials as specified in the chart.

Some phrases in this document may not apply to your health plan's/M+C organization's benefit package or marketing strategy. We caution you to apply the information contained in this document with the understanding that it must be evaluated for applicability to your health plan/M+C organization.

Listed below are items that apply to the various pre-enrollment/member retention marketing scenarios experienced by Medicare managed care contracting entities:

Operational Items

1. ***Lock-In Statement:*** The concept of "lock-in" must be clearly explained in all materials. For marketing pieces, which tend to be of short duration, we suggest: "You must receive all routine care from plan providers" or "You must use plan

providers except in emergent care situations or for out-of-area urgent care/renal dialysis." However, in all written materials used to make a sale, a more expanded version is suggested: "If you obtain routine care from out-of-plan providers neither Medicare *nor* [name of health plan/M+C organization] will be responsible for the costs." Modify materials if the health plan has a Point-of-Service (POS) or Visitors' Program benefit or is a cost *plan,* Private Fee-For-Service Plan (PFFS)*, or PPO*.

2. ***Networks and Sub-networks:*** All marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.

3. ***Hours of Operation:*** Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. This requirement does not apply to any numbers included on advertising materials for persons to call for more information.

4. ***Disclaimers- Exception for*** **Outdoor Advertising (ODA):** ODA is marketing material intended to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised. Due to the nature of ODA, CMS is willing to waive the disclaimer information required with other forms of marketing media (e.g., lock-in and premium information).[3]

5. **Marketing Material Identification Systems:** Health plans/M+C organizations must use the system mandated by the reviewing RO for identifying marketing materials submitted to CMS. If the reviewing RO does not have a system, health plans/M+C organizations may use their own system for identifying marketing materials. The health plan identifier should appear on the lower left or right side of the marketing piece. After the RO approves the marketing piece, the approval date (month/year) should always be posted to the marketing piece. The approval date is the date on the CMS approval *notice*. This requirement is *also* applicable to all approved Internet pages and paper advertisements (e.g. brochures, newspaper ads). Approved radio, television, *and billboard* marketing materials need not include mention of the approval date*/ID number*.

6. ***Identification of All Plans in Materials:*** Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR)s Proposals and the Plan Benefit Package (PBP)s covering the same service area (or portions of the same service area), there is no requirement that all plans be identified in all of the health plan's/M+C organization's marketing materials, although M+C organizations may do so at their discretion. M+C organizations must disclose whether other plans are available in their Annual Notice of Change letter.

7. ***Marketing to Members of Non-Renewing Medicare Plans:*** The M+C organizations may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the following requirements are met:

    - No such marketing is permitted until after the date the beneficiary has received the plan termination letter; and

    - In addition to the targeted message, the marketing piece must contain a statement indicating that the plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.

8. ***Sales Scripts:*** Sales scripts, both for in-home and telephone sales use, must be reviewed by CMS prior to use. However, health plans/M+C organizations are not required to adhere to a specific format for submission (i.e. verbatim text or bullet points).

9. ***Member Lists:*** Health plans/M+C organizations may not use Medicare member lists for non-plan-specific purposes. If a health plan/M+C organization has questions regarding specific material, which it wishes to send to its Medicare members, the material should be submitted to CMS for a decision.

10. ***Banner and Banner-Like Advertisements:*** *Health plans/M+C organizations are not required to include the disclaimer information that is required with other forms of marketing media (e.g., lock-in and premium information) for banner or banner-like advertisements. "Banner" advertisements are typically used in television ads, and flash information quickly across a screen with the sole purpose of enticing a prospective enrollee to call the organization for more information. This type of ad does not contain benefit or cost sharing information. A "banner-like" advertisement is usually in some media other than television, is intended to very briefly entice someone to call the organization or to alert someone that information is forthcoming and, like a banner ad, does not contain benefit or cost sharing information*

11. ***Member ID Cards:*** *The CMS recommends that all health plans/M+C organizations, especially PPOs and PFFS Plans, include the phrase "Medicare limiting charges apply" on Member ID cards. However, use of this phrase is optional. The CMS believes that use of this phrase on a card that most providers will see is a reliable method of informing providers of the billing rules for the plan, and thus could reduce the chance for incorrect or inappropriate balance billing.*

    The CMS also recommends that PFFS Plans include the statement that the provider should bill the PFFS organization and not Original Medicare. The CMS believes this statement will help prevent claim processing errors. However, use of this statement is optional.

12. ***Option to Choose Media Type:*** *With respect to the SB, the EOC, and the Provider Directory, health plans/M+C organizations have the option of contacting members to determine in what format they would like to receive the materials (e.g., hardcopy, CD ROM, Internet Web pages, etc.). Health plans/M+C organizations must contact members in writing (e.g., by letter, postcard, newsletter article, etc.) to determine whether they would like to receive the SB, EOC, and/or the Provider Directory in another format. If the organization does not receive a response from the member, then the organization must assume that the member wants to receive the information in hardcopy.*
If the organization sends one provider directory to an address where up to four members reside (as allowed in §40.2), then it may send one written notice regarding choice of media type to that address (if it is notifying members by letter), rather than one notice to each individual member at that address. A reply from one member at that address constitutes a reply for the entire address.

The following would also apply:

- *The member must receive the materials in the required time frames, regardless of the format.*

- *For the EOC and the SB, if the organization will be providing any of these marketing materials via an Internet Web page, then it must establish a process for informing members when that Web page has been updated. For example, the organization could notify members by newsletter article, by E-mail, by postcard, etc. Often any change in the EOC or SB is communicated to all members by newsletter and notification that the change has been made on the web page could be made at the same time. This requirement does not apply to provider directories since provider directory updates can occur far more frequently than updates to the EOC or SB.*

- *The non-hardcopy format should match the approved hardcopy format, and if it does, it will not need additional CMS approval. If anything is added or deleted, the non-hardcopy format must receive separate CMS approval.*

  Note: *Some health plans/M+C organizations use a database/search function for their provider directory on the Internet. In this case, as long as the information that comes up on a specific provider is the same information as what is contained in the hardcopy format, then the Internet provider directory would be considered to be the same as the hardcopy format and would not need additional CMS approval.*

Affiliation Acknowledgements

1. ***Contracting Statement:*** All marketing materials must include a statement that the health plan/M+C organization contracts with the Federal government. One possible statement is "A Federally Qualified HMO with a Medicare contract." Cost-contractors may use "An HMO with a Medicare contract" and/or "An M+C organization with a Medicare contract" if they are State licensed as HMOs. Medicare+Choice organizations may identify Medicare products as "An HMO with a Medicare+Choice contract" if they are Federally Qualified or State licensed as HMOs. M+C organizations may also identify their Medicare plans as "An M+C plan with a Medicare+Choice contract," or "A Coordinated Care Plan with a Medicare+Choice contract," if the health plan/M+C organization meets the requirements of §1851(a)(2)(A) of the *Social Security* Act. In addition, an M+C organization may describe its Medicare product as a "Medicare+Choice plan offered by [name of M+C organization], a Medicare+Choice Organization".

2. ***Provider Sponsored Organizations (*PSO*):*** An M+C organization may only identify itself as an "M+C *Provider Sponsored Organization (*PSO*)*" or imply that it is one of the PSO options for Medicare beneficiaries under M+C if it has received a State licensure waiver from CMS in accordance with 42 CFR 422.370 - .378. State licensed M+C organizations may identify themselves in marketing materials as a "Provider Sponsored Organization (PSO)," a "State licensed PSO with a M+C contract," or any other term generally applied to managed care organizations that are sponsored by health care providers as long as they do not use the specific term "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the Balanced Budget Act of 1997 and implementing regulations at 42 CFR 422.350 - .356.

3. ***Ethnic and Religious Affiliations:*** The M+C organizations are permitted to use ethnic and religious affiliation in their plan names, as long as the legal entity offering the plan has a similar proper name/affiliation. For instance, if a plan were affiliated with the Swedish Hospital of Minnesota, it would be permissible for the plan to use the tag line, "Swedish Plan, offered by Swedish Hospital System of Minnesota."

Special Situations

1. ***Disability Population:*** Beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach. Specifically, and in light of the publication of the final M+C regulation, health plans/M+C organizations may not use plan names that suggest that a plan is available only to Medicare beneficiaries age 65 or over, rather than to all beneficiaries. This prohibition generally bars plan names involving terms such as "seniors," "65+," etc. In fairness to M+C organizations with an existing investment in a plan name, CMS will allow the "grandfathering" of M+C plan names established before the final rule took effect *(i.e., before June 29, 2000).*

2. ***TDD/TTY Numbers:*** TDD/TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TDD/TTY number must also appear along with the hours of operation, if the inclusion of hours of operation are required (as outlined under "Operational Items," item #3). The font size/style rule is required for all media with the exception of television ads. The CMS recognizes that the requirement that the TTY/TDD number be the same font and style as other numbers can result in confusion on a television ad, resulting in some prospective enrollees calling the wrong phone number. Therefore, health plans/M+C organizations are allowed to use various techniques to sharpen the differences between TTY/TDD and other phone numbers on a television ad (such as using a smaller font size for the TTY/TDD number than for the other phone numbers).

3. **Review of marketing materials in non-English language or Braille:** For marketing with non-English or Braille materials the health plan/M+C organization must submit the non-English or Braille version of the marketing piece, an English version (translation) of the piece, and a letter of attestation from the health plan/M+C organization that both pieces convey the same information. Health plans/M+C organizations will be subject to verification monitoring review and associated penalties for violation of this CMS policy. *In addition to verifying the accuracy of non-English marketing materials through monitoring review, CMS will also periodically conduct marketing review of non-English materials on an "as needed" basis. If materials are found inaccurate, health plans/M+C organizations may not distribute materials until revised materials have been approved.* If national health plans/M+C organizations have submitted materials in English to the lead RO and these have been approved, the same materials in other languages or Braille may be used provided that health plans/M+C organizations submit attestation letters vouching that the non-English or Braille version contains the same information as the English language version.

Section 1876 Cost Contracts Only

1. For §1876 of the Social Security Act, cost-contracting health plans only - In all marketing materials (e.g., brochure narratives and introductions to side-by-side comparisons) the health plan must indicate that it meets Medicare regulatory requirements for providing enrollment opportunity and benefit packages for both Part A and B and Part B-only eligible beneficiaries.[4]

2. Cost-contracting health plans must market a low option or basic benefit package that is identical to the Medicare fee-for-service benefit package (except for any additional benefits the health plan may offer at no charge, for which the health plan claims no reimbursement). Information on the availability of this package must appear in all of the health plan's marketing materials. The health plan/M+C organization may also offer additional optional enriched benefit packages for an additional charge to the extent they wish.

Preferred Provider Organizations (including PPO Demonstrations) Only

1. ***Cost Savings Described in Marketing Materials:*** *If a PPO states in marketing materials that prospective enrollees will save money if they join the plan, it must also acknowledge the added cost of accessing services out-of-network.*

2. ***Preferred and Non-Preferred Benefits****: If a PPO offers benefits for which the coinsurance is the same percentage both in and out of network, the PPO must make it clear in all non-advertising pre-enrollment material that the member's responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not the contracted amount.*

3. ***Mandatory Supplemental Benefits:*** *If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are offered at the non-preferred benefit level. The EOC must specifically explain which benefits are offered at the non-preferred benefit level and any limitations that may apply.*

4. ***Prior Notification / Authorization Requirements:*** *Some PPOs may require or request that members notify them prior to receiving certain services. In these cases, the organization must clearly define the requirement in marketing materials. It must also include the information in the PBP Notes section so that the appropriate language regarding the penalty may be used in marketing materials. If there is a penalty for not receiving prior referral/notification/authorization, marketing materials that mention these services must clearly describe the penalty.*

Editorial Items

1. **Font Size Rule for Member Materials:** Readability of written materials is crucial to informed choice for Medicare beneficiaries. All member materials that convey the rights and responsibilities of the health plan/M+C organization and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to, the EOC or member brochure and contract, the enrollment and disenrollment applications, letters confirming enrollment and disenrollment, notices of non-coverage (NONC) and notices informing members of their right to an appeals process. The CMS is cognizant of the fact that, when actually measured, font size 12 point may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if health plans/M+C organizations choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12 point.

Exceptions:

- *Due to the size of the member ID card, the member ID card need not have all information in a 12-point font size or larger.*

- *If an organization publishes a notice to close enrollment (as required in Chapter 2) in the Public Notices section of a newspaper, the organization need not use 12-point font and can instead use the font used by the newspaper for its Public Notices section.*

2. **Font Size Rule for Notice and Non-Notice Materials:** *The 12-point font size or larger rule also applies to any footnotes or subscript annotations in notices. In all non-notice material (e.g., TV advertisements) the footnote and any text appearing in the material must be the same size font as the commercial message. The term "commercial message" refers to the material, which is designed to capture the reader's attention regarding the health plan/M+C organization. The term does not refer to the commercial membership (i.e., non-Medicare/Medicaid members) of the health plan/M+C organization. All non-notice materials must have the same font size for both the commercial message and footnotes. The size is left to the discretion of the health plan/M+C organization and can be smaller than size 12-point font, but the commercial message and footnotes must be the same size font.*

3. ***Footnote Placement:*** Health plans/M+C organizations must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. In other words, for example, the health plan/M+C organization cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

Other

1. **Marketing through the Internet:** The CMS considers the Internet as simply another vehicle for the distribution of marketing information. Therefore, all regulatory rules and requirements associated with all other marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to health plan/M+C organization marketing activity on the Internet. The CMS marketing review authority extends to all marketing activity (both advertising and beneficiary notification activity) the health plan/M+C organization pursues via the Internet.

2. ***Reference to Studies or Statistical Data:*** M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, etc. as long as specific study details are given (at a minimum source, dates, sample size, and number of plans surveyed). M+C organizations may not use study or statistical data to directly compare their plan to another. If M+C organizations use

study data that includes information on several other M+C organizations, they will not be required to include data on all organizations. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

3. ***Logos/Tag Lines:*** The CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising marketing materials. The guidelines regarding specifically the use of unsubstantiated statements that apply to advertising materials do not apply to logos/taglines. Contracting health plans may use unsubstantiated statements in their logos and in their product tag lines (e.g., "Your health is our major concern," "Quality care is our pledge to you," "First Care means quality care," etc.). This latitude is allowed only in logo/product tag line language. Such unsubstantiated claims cannot be used in general advertising text regardless of the communication media employed to distribute the message. Not withstanding the ability to use unsubstantiated statements as indicated above, the use of superlatives is not permitted in logos/product tag lines (e.g., "First Care means the first in quality care" or "Senior's Plus means the best in managed care"). Refer to the Must Use/Can't Use/Can Use chart in §30.3 of this chapter for full information on restrictions associated with the use of superlatives.

30.2 - Sales Package Minimum Information Requirements

(Rev. 4, 10-01-01)

This section contains guidance regarding rules that health plans/M+C organizations are required to provide in writing to beneficiaries prior to enrollment.

30.2.1 - Lock-in Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO

(Rev. 11, 08-15-02)

Health plans/M+C organizations must describe rules for receipt of primary care, specialty care, hospital care, and other medical services in their EOC. These rules may vary by health plan/M+C organization. Health plans/M+C organizations must disclose specific rules for referrals for follow-up specialty care in their EOC. Prior to enrollment, prospective members must be able to obtain information regarding the health plan network coverage and rules in sufficient detail to make an informed choice.

When a beneficiary enrolls in a plan/M+C organization, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services.

Contractors with a POS benefit or Visitors Program benefit should list plan-specific requirements and level of coverage found in your EOC.

A plan member selects a primary care physician (PCP) to coordinate all of the member's care. A primary care physician is usually a family practitioner, general practitioner, or internist. The primary care physician knows the plan's network and can guide the member to plan specialists when needed. The member always has the option to change to a different primary care physician. Changes in PCP will be effective according to the plan guidelines that, in some instances, could be the first or the 15th day of the following month as opposed to immediately.

Neither the health plan/M+C organization nor Medicare will pay for medical services that the member receives outside of the network unless it was authorized, or it is an emergency, urgently needed care, or out-of-area dialysis service. The member may be responsible for paying the bill.

In the case of enrollees in §1876 Cost Contracts, enrollees must be informed that after enrollment is effective, in order for them to receive the full coverage offered, services other than emergency and urgently-needed services must be obtained through the HMO or CMP. In the case of cost enrollees, however, they may receive services that are not provided or arranged by their HMO or CMP, but they would be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare program. They also would be liable for any charges not covered by the Medicare program.[5]

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30.2.2 - Emergency Care *(Cross References to QISMC 2.3.17)*

(Rev. 11, 08-15-02)

Members are not required to go to health plan-affiliated hospitals and practitioners when they experience an emergency. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

1. Furnished by a provider qualified to furnish emergency services; and

2. Needed to evaluate or stabilize an emergency medical condition.

For information on M+C organization responsibility for emergency care stabilization and post-stabilization requirements see 42 CFR 422.113(b)(3),(c)(2)(i) through (iii).

Describe precisely where emergency coverage will be available under the health plan/M+C organization (e.g., the United States and its Territories, worldwide, etc.).

30.2.3 - Urgent Care

(Rev. 4, 10-01-01)

Urgently needed services means covered services provided when an enrollee is temporarily absent from the M+C plan's service area (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury, or condition; and

2. It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

Urgently needed care provided by non-plan providers is covered when a member is in the service area or continuation area under the unusual circumstance that the organization's provider network is temporarily unavailable or inaccessible. Normally, if a member needs urgent care and is in the health plan's/M+C organization's service area or continuation area, the member is expected to obtain care from the health plan's/M+C organization's providers.

30.2.4 - Appeal Rights

(Rev. 11, 08-15-02)

Members have a right to appeal any decision the health plan/M+C organization makes regarding, but not limited to, a denial, termination, payment, or reduction of services. This includes denial of *payment for a* service after the service has been rendered (post-service) or denial of service prior to the service being rendered (pre-service).

30.2.5 - Benefits and Plan Premium Information

(Rev. 11, 08-15-02)

Premium information must include the statement: "You must continue to pay your Medicare Part B premium."

When specifying benefits, annual limits (e.g., $1,000 annual maximum for prescription drugs), annual benefit payout (e.g., $700 for eyeglasses every 2 years) and applicable copayments (e.g., $5 copayment for a doctor visit) must be specified. Major exclusions and limitations must be stated clearly. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained. Health plans/M+C organizations must state clearly all monetary limits, as well as any restrictive policies that might impact a beneficiary's access to drugs or services. When annual dollar amounts or limits are provided, the health plan/M+C organization must also mention the applicable quarterly or monthly limits, and whether any unused portion of that benefit can be carried over from one calendar quarter to the next. Include a closing statement such as: "For full information on [plan/M+C organization name] (e.g., drugs, routine physical exam, eyeglasses, dental, etc.) benefits, call our Customer Service Department at [plan/M+C organization phone number]."

Also, a statement must be made that the (Health Plan/M+C organization's Name) contract with CMS is renewed annually, and that the availability of coverage beyond the end of the current contract year is not guaranteed.

Cost contractors must describe their premiums and cost-sharing for services received through the HMO or CMP, and any optional supplemental benefit packages they offer. They must also indicate that premiums, cost-sharing, and optional supplemental benefits may change each year, and that the HMO or CMP may decide not to renew its contract for a given calendar year.

30.3 - "Must Use/Can't Use/Can Use" Chart

(Rev. 9, 04-01-02)

The "Must Use/Can't Use/Can Use" Chart provides guidance on language that M+C organizations must use, can't use, and can use in pre-enrollment advertising.

The following chart provides guidance on language that M+C organizations must use, can't use, and can use in pre-enrollment advertising. The following items: Lock-in, Eligibility, and Contract with the Government are required items in advertising. The use of any language found in the "Can Use" column is discretionary.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
Lock-In	- Enrolled members "must use (name of health plan/M+C organization) (contracting, affiliated, or name of health plan/ M+C organization participating) providers for routine care" - "Health plan/M+C organization available to all Medicare beneficiaries" MEDIA: All except outdoor advertising - Outdoor advertising has the option of excluding this topic: - See definition of outdoor advertising in §10 of this Chapter. This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece	- The term "Participating Providers"		CMS requires lock-in for all media to inform beneficiaries of managed care requirement. Because of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising
Descriptions of the M+C organization's Quality [6]		- Superlatives (e.g., highest, best) [7] - Unsubstantiated comparisons with other M+C organizations	-Qualified superlatives (e.g., among the best, some of the highest) - Superlatives (e.g., ranked number 1, if they can be substantiated by ratings.	

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
		- Direct negative statements about other M+C organizations including individual statements from members or former members	studies or statistics(Source must be identified in the advertising piece.) See §30.1 for more information. - "Health plan/M+C organization delivers (adjective) quality of care" - Can use satisfaction survey results. E.g.,"The (name of specific study) indicated we rated highest in member satisfaction." (Must disclose year and source.) See §30.3 for more information. - M+C organizations may use CAHPS survey data regarding their own organization but may not use it to make specific comparisons to other M+C organizations. MEDIA: All	
Premium Costs	- If a health plan/M+C organization premium is mentioned, it must be accompanied by a statement that beneficiaries must continue to pay Part B premium or Medicare premium. - If an annual dollar	- "No premium" - "No premium or deductible" - "Free"	The following may be used: - "No health plan/M+C organization premium" - "Health plan/M+C organization premium equals _____" - "$0 health plan/M+C organization premium"	Materials must disclose that beneficiaries must continue to pay the Part B premium and continue their Medicare Part B coverage while enrolled in the HMO.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
	amount/limit is mentioned, quarterly or monthly limits must also be mentioned as well as any ability to carry over any remaining benefit from quarter to quarter. Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising. MEDIA: All except outdoor advertising - TV-Part B caveat must be flashed in TV safe range or mentioned in narration.[13]		- At no extra cost to you" but only if referring to a specific benefit - "No health plan/M+C organization premium or deductibles" - "No premium or deductibles (you must continue to pay the Medicare Part B premium" - "No premium beyond your monthly Medicare payment" - "No premium other than what you currently pay for Medicare" MEDIA: All except outdoor advertising, which has the option of excluding this topic.	
Testimonials	- Content must comply with CMS marketing guidelines, including statements by members - Speaker must identify specific health plan/ M+C organization membership - Ads must include a verbal statement by member indicating that she/he is a member of a specific plan	- Cannot have non-members say he/she belongs. (Can use actors, but they cannot say they belong to the health plan/M+C organization.) - *"Health plans/M + C organizations cannot use negative testimonials about other plans from members or ex-members."*		

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
	or a "banner" at the bottom of the screen indicating the same or a voice over identifying the member as an enrollee of the specific plan. MEDIA: All			
Contract with the Government	- Must include one of the phrases from the "Can Use" column MEDIA: All except outdoor. Outdoor advertising, which has the option of excluding this topic. This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.	- "Recommended or endorsed by Medicare" - Cannot imply that health plan/M+C organization has a unique or custom arrangement with the government, e.g.: -- "Special contract with Medicare" --"Special health plan/M+C organization for Medicare beneficiaries"	- "An HMO with a Medicare contract" - "An M+C organization with a Medicare contract" - "A Federally Qualified HMO with a Medicare contract" - "A Federally Qualified Medicare contracting HMO" - "Medicare approved HMO" - "A Coordinated Care Plan with an Medicare+Choice contract" - "M+C PSO" MEDIA: All	Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
Physicians and Other Health Care Providers	- If the number of physicians and other health care providers is used, it must include only those available to Medicare beneficiaries MEDIA: TV, radio, outdoor - If the number of physicians and other health care providers is used, it must include only providers available to Medicare beneficiaries. If a total number is used it must separately delineate the number of primary care providers and specialists included. MEDIA: Print and direct mail - If the M+C organization uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing beneficiaries of providers that are associated with the M+C organization's	- Implication that providers are available exclusively through the particular HMO unless such a statement is true - "Participating providers" unless you use health plan/M+C organization name - The M+C organization may not identify itself by the name of a participating provider or provider group, with the exception of a PSO.	- "(Health plan/M+C organization's name) participating providers" - "Plan" providers - "Network" providers - "Contracting" providers - "Affiliated" providers - Number of providers should be same total number of Medicare providers MEDIA: All	Do not use the word "participating" when referring to health plan/M+C organization providers (unless you use health plan/M+C organization name), since it could be confused with a participation agreement with Medicare. Health plan/M+C organizations should either use "contracting" or "health plan/M+C organization name" when referring to health plan/M+C organization providers. It must be clear to the beneficiary with whom the M+C contract with CMS is held.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
	delivery system. MEDIA: Print and direct mail			
Eligibility	- Must indicate that beneficiaries must be entitled to Part A and enrolled in B - For M+C plans -- Must indicate that all Medicare beneficiaries with Parts A and B of Medicare may apply -For §1876 cost contracting health plans: -- Must indicate that all Medicare beneficiaries may apply This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.	"No health screening" unless specific mention is made of ESRD "Seniors" unless term appears with "and all other Medicare eligibles" "Health plan/M+C organization designed especially for seniors" "Senior health plan/M+C organization" unless part of health plan/M+C organization name "Individuals age 65 and over"	- "Anyone with Medicare may apply" - "Medicare entitled by age or disability" - "Individuals eligible for Medicare by age or disability" - "Individuals on or entitled to Medicare by age or disability" - "Medicare beneficiaries" - "Medicare enrollees" - "People with or on Medicare" - "No physicals required" - "No health screening" if a caveat is included for ESRD - "Grandfathered enrollees" MEDIA: ALL	Since all Medicare beneficiaries may enroll in Medicare-contracting HMOs, you may not refer to your health plan/M+C organization as a "senior health plan/M+C organization" (unless you refer to it as part of the health plan/M+C organization name). The term "senior health plan/M+C organization" implies that disabled beneficiaries may not enroll. Medicare Part A is not a requirement for enrollment in Medicare-cost contracting HMOs. M+C organizations may only enroll individuals with both Parts A and B of Medicare, with the exception of "grandfathered" members.
Claims Forms / Paperwork		"No paperwork" "No claims or paperwork/complicated paperwork" No claims forms"	"Virtually no paperwork" "No paperwork when using health plan/M+C organization providers" "Hardly any paperwork" MEDIA: All	Members may be required to submit bills or claims documentation when using out-of-plan providers.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
Benefits: a) Comparison	- If premiums and benefits vary by geographic area, must clearly state this or must clearly state geographic area in which differing premiums and benefits are applicable. - If only benefits vary, clearly state geographic area in which benefits are applicable. MEDIA: All	- Minimal co-pays may vary by county - Minimal co-pays may apply	- "Premiums and benefits may vary by county" or "These benefits apply to the following counties"* - "Except for _____ county"* MEDIA: All - M+C organizations may compare benefits to Medigap plans as long as information is provided accurately and in detail.	Premiums, benefits, and/or copayment amounts may vary by county within a given service area. This must be clearly conveyed in all marketing materials.
Benefits: b) Limitations		- "At no extra cost to you" or "free" if co-pays apply	- State exact dollar amount limit on any benefit - "Limitations and restrictions may apply" - "Minimal copayments will apply" - "Minimal copayments vary by county"* - State which benefits are subject to limitations MEDIA: All	If benefits are specified within the piece, any applicable copayment should be stated or you may include the general statement as shown.
Benefits: c) Prescription Drugs	- If prescription drugs are mentioned and have limitations, must say: - Limited outpatient drug coverage; or, - Drug coverage benefits	- "We cover prescription drugs" unless accompanied by reference to limitation - "Prescription drug coverage" unless	- Fully disclose dollar amount of copayments and annual/quarterly/monthly limit - If limited, you must say so - Limited outpatient drug	Prescription drugs are an important benefit that must be adequately described. Any dollar limits must be clearly conveyed.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
	subject to limitations; or - Up to xxx annual/ quarterly/ monthly limit or xxx limit per year/quarter/month and other limits and restrictions may apply. - Copayment amounts and indicate for a xx number of days supply - If benefits are restricted to a formulary, this must be clearly stated. - In addition, must state: - that formulary contents are subject to change within a contract year without advance notice - health plan/M+C organization should be contacted for additional details. MEDIA: All	accompanied by reference to limitation	coverage with xx copayments for xx number of days supply and xxx annual/quarterly/monthly limit - "Prescriptions must be filled at contracting or health plan/M+C organization affiliated pharmacies." MEDIA: All	
Benefits: d) Multi-Year Benefits	- Whenever multi-year benefits are discussed, M+C organizations are required to make appropriate disclosure that the benefit may not be available in subsequent		- "[benefit] may not be available in subsequent years" OR - "[name of M+C organization] contracts with Medicare each year, this benefit may not may not be	Potential applicants and members must be informed in marketing materials that multi-year benefits in current year benefit packages are not guaranteed in future contract years.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
	years. MEDIA: All, where multi-year benefit(s) are mentioned		available next year" MEDIA: All, where multi-year benefit(s) are mentioned	
- Definitions - Emergency and Urgently Needed Care		- "Life threatening" - "True emergency"	- Emergency - definition as stated in current CMS policy. - Urgent - definition as stated in current CMS policy. MEDIA: All	Emergency and urgent care criteria should be explained per Medicare guidelines rather than in the commercial context.
Drawings / Prizes		- "Eligible for free drawing and prizes" MEDIA: Direct mail, flyers, print advertising	- "Eligible for a free drawing and prizes with no obligation" - "Free drawing without obligation" MEDIA: Direct mail, flyers, print advertising.	It is a prohibited marketing practice to use free gifts and prizes as an inducement to enroll. Any gratuity must be made available to all participants regardless of enrollment. The value of any gift must be less than the nominal amount of $15.
Sales presentations	- "A sales representative will be present with information and applications." MEDIA: Flyers and invitations to sales presentations - "A sales representative may call."	- "A health plan representative will be available to answer questions."		This phrase must be used whenever beneficiaries are invited to attend a group session with the intent of enrolling those individuals attending. This phrase must be included on any response card in which the beneficiary is asked to provide a telephone number.

"Must Use/Can't Use/Can Use" Chart				
Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
	MEDIA: Response card where the beneficiary's phone number is requested - "A telecommunications device for the deaf (TDD) is available to get additional information or set up a meeting with a sales representative." MEDIA: All - "For accommodation of persons with special needs at sales meetings, call (Health Plan Phone Number)." MEDIA: Flyers and invitations to sales meetings			All Health plans must indicate in all advertising that a telecommunication device for the deaf (TDD/TTY) is available to get additional information or to set up a meeting with a sales representative.

Note: Flexible benefits are not permitted under the M+C program. Therefore, premiums, co-pays and benefits may not vary by county for the same M+C plan.

40 - Guidelines for Beneficiary Notification Materials

(Rev. 28, 08-01-03)

The definition of marketing materials includes all notification forms and letters and sections of newsletters that are used to enroll, disenroll, and communicate with the member on many different membership operational policies and procedures. These materials are also described as beneficiary notification materials and subject to specific CMS requirements. Section 40.1 of this chapter provides general guidance with respect to beneficiary notification materials. Section 40.2 provides specific guidance with respect to provider directories. Section 40.3 provides specific guidance about the use of drug formularies.

40.1 - General Guidance for Beneficiary Notification Materials

(Rev. 4, 10-01-01)

40.1.1 - Use of Model Beneficiary Notification Materials

(Rev. 4, 10-01-01)

Beneficiary notification materials are those materials used by health plans/M+C organizations to convey benefit or plan operational information to potential or enrolled beneficiary health plan members.

The passage of the Benefits Improvement and Protection Act of 2000 has changed the review process for model beneficiary notification materials, for specific guidance on these changes and the usage of model beneficiary notification materials, see §20 - "Marketing Review Process."

40.1.2 - Use of Standardized Beneficiary Notification Materials

(Rev. 15, 09-27-02)

The CMS has implemented certain standardized beneficiary notification marketing materials for health plan participants in Medicare managed care. In particular, all M+C organizations are required to use a standardized Summary of Benefits (SB). Use of standardized materials by health plans/M+C organizations is mandatory.

Employer group health plans (EGHPs) were granted an exemption from this requirement to use the standardized Summary of Benefits while CMS conducted a review to determine whether EGHPs should receive a permanent exemption. After discussions with various interested parties, including employer groups, consulting firms, beneficiary advocacy groups, and employer unions, CMS has decided to exempt EGHPs from the requirement to use CMS' standardized summary of benefits.

40.1.3 - Model Annual Notice of Change

(Rev. 28, 08-01-03)

All M+C organizations are required to give members notice of Medicare program and health plan changes taking place on January 1 of the upcoming year, by October 15 of the current year. Cost plans must give notice within 30 days of the effective date of the Medicare program and health plan changes (i.e., by December 1 for January 1 changes). This requirement applies to all plan enrollees, including employer group enrollees. "Give notice" means that members must have ***received*** *the notice by the required date. This notice is known as the "Annual Notice of Change," or "ANOC."*

The ANOC must be member specific. This means that the notice must have the member's own name either on the envelope addressed to the member or on the ANOC itself. The following is a model ANOC for M+C organizations and cost plans.

MODEL ANNUAL NOTICE OF CHANGE

Dear [member name] - or - [Member]:

[Note: The organization may modify this introductory paragraph to tailor it to its needs, as long as the paragraph is kept brief.] This is the time of year when we like to thank you for your membership and inform you of new plan changes for the upcoming year. Beginning January 1, [insert upcoming year], there will be some changes to [insert plan name]. These changes are described in this letter.

How will my monthly premiums change?

Starting January 1, [insert upcoming year], the monthly premium that you pay to [insert plan name] will [increase/decrease] from $____ to $____ OR stay the same at $____.

How will my benefits and costs change?

[Clearly describe all benefit changes, including changes in cost sharing, annual drug cap, drug coverage, and any new benefits that will be offered by the plan in the coming year or that will be covered by Medicare. Also describe any benefits offered in the current year that will no longer be offered by the plan in the upcoming year. When describing benefit changes, do so by comparing the current year benefit with the upcoming year benefit.]

We have enclosed a summary of your benefits, premiums and copays that will be effective January 1, [insert upcoming year]. [M+C organizations: Insert whichever of the two

following sentences is appropriate for your circumstance: (1) "Medicare has reviewed and approved the changes in benefits, premiums, and other costs included in this letter and on the enclosed Summary of Benefits" or, (2) "The changes in benefits, premiums, other costs included in this letter and on the enclosed Summary of Benefits are pending Federal approval."] [Cost plans insert the following sentence: Medicare has reviewed the changes in benefits, premiums, and other costs included in this letter and on the enclosed Summary of Benefits"] We will send you an [insert: "Evidence of Coverage" or whichever name is used by your MCO as the name for the EOC] [insert either "by [date]" or "at a later date"]. All changes begin January 1, [insert upcoming year], and will be in effect through December 31, [insert upcoming year]. Rest assured that you will be a member of [insert plan name] for the coming year if you do nothing to change your Medicare coverage.

[If the organization lists more than one plan offering on the enclosed SB, the organization must identify the specific plan in which the member will be enrolled. In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information.]

Are there other benefits I can get?

[Include this section if the plan offers optional supplemental benefits.]

[Clearly describe any optional supplemental benefits and the premiums for those benefits. A description of the process that the member must follow to elect optional supplemental benefits must also be included.]

Where can I get more information?

Please call our Member Services Department [insert days and hours of operation], at [insert phone number] if you have any questions. TTY users should call [insert TTY phone number].

You can contact us if you need additional information, including:

- *Information about how we control the use of services and costs;*

[Cost plans do not need to include the remaining three bullets]

- *Information on the number of appeals and grievances filed by our members;*
- *A summary description of how we pay our doctors;*
- *A description of our financial condition, including a summary of our most recently audited statement.*

You can also get information about the Medicare program and Medicare health plans from the www.medicare.gov Web site or by calling 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, including weekends, to answer questions about Medicare.

We look forward to serving you now and in the future.

Sincerely,

Plan Representative

ENCLOSURE - Summary of Benefits

40.2 - Specific Guidance About Provider Directories

(Rev. 20, 04-04-03)

Regulations at 42 CFR 422.111(b) require that M+C organizations disclose the following information to each enrollee electing an M+C plan offered by the M+C organization:

1. The number, mix, and distribution, including addresses of providers from whom enrollees may obtain services, as well as any out-of-network coverage or point-of-service option;

2. Information regarding out-of-area coverage and emergency coverage, including the process and procedures for obtaining emergency services, and the location where emergency care can be obtained, as well as other locations where contracting physicians and hospitals provide emergency services, and post-stabilization care included in the M+C plan;

3. Prior authorization rules and other review requirements that must be met in order to ensure payment for the services; and

4. Instructions to enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the M+C organization for processing and determination of enrollee liability, if any.

Section 422.111(a) requires that this information be disclosed in clear, accurate, and standardized form at the time of enrollment and at least annually thereafter.[9] M+C organizations generally include this information in their provider directory and distribute the directory to new members upon enrollment and existing members on an annual basis.[10] In addition to the information provided above, provider directories should also contain the following:

1. Names, complete addresses, and phone numbers of the primary care physicians;

2. Names and addresses (city or town) of specialists, skilled nursing facilities, hospitals, outpatient mental health providers, and pharmacies, where outpatient prescription drugs are offered by the M+C plan;

3. General information regarding lock-in, including the role of the primary care physician (PCP) as well as the process for selecting a new PCP and any specific requirements for referrals to specialists and ancillary providers;

4. A description of the plan's service area, including a list of cities and towns;

5. Telephone numbers for customer service or appropriate contact information (including the hours of service) for members who have questions or require assistance in selecting a PCP; [11] and

6. A general disclaimer that indicates that the directory is current as of a particular date and that a provider's listing in the directory does not guarantee that the provider is still in the network or accepting new members.

The M+C organizations may publish separate PCP and Specialty directories provided that both directories must be given to enrollees at the time of enrollment and at least annually thereafter. M+C organizations that use sub-networks of providers must clearly delineate these sub-networks (preferably by listing the providers as a separate sub-network) and describe any restrictions imposed on members that use these sub-networks. This is particularly important since beneficiaries could choose their primary care physician without realizing that this choice restricts them to a specified group of specialists, ancillary providers, and hospitals. M+C organizations must also clearly describe the process for obtaining services in these networks and sub-networks, including any referral requirements, as well as any out-of-network coverage or point-of-service option.

The M+C organizations may find it more economical to print a separate directory for each sub-network and disseminate this information to members in a particular sub-network. This practice is permissible, provided that the directory clearly states that a directory that lists providers for other networks is available and provides this information to members upon request.

With respect to the annual mailing of the directory, health plans/M+C organizations have the option to either mail one directory to every member, or to mail one directory to every address where ***up to four members*** *reside. (Keep in mind that individuals in, for example, apartment buildings, are only considered to be at the "same address" if the apartment number is the same.) Please note that every member must still receive his or her own directory at the time of enrollment.*

If you choose to mail the directory to every address where up to four members reside, you must keep the following in mind:

- *If a member at that address subsequently requests that you mail another copy of the directory, you must mail them a directory.*

- *When mailing a directory to one address, you should include the name of at least one of those individuals in the mailing address (however, we prefer that you include the names of all individuals, to prevent any members mistakenly believing that you failed to mail them a directory).*

Please also refer to §30.1, "Operational Items #12," which contains more information regarding mailing of the Provider Directory.

40.3 - Specific Guidance About Drug Formularies

(Rev. 15, 09-27-02)

In providing a prescription drug benefit, a health plan/M+C organization may rely on a formulary. A formulary is a list of prescription drugs, grouped by therapeutic drug class. There are three categories of formularies: open, preferred, and closed. Open formularies list all drugs and drug products that are covered and do not place restrictions on coverage of drugs within each *therapeutic* class (i.e. the physician can order any one in the class). Preferred formularies are similar to open formularies, but also use incentives and interventions to encourage use of certain preferred drugs. Closed formularies use limited lists of drugs; enrollees pay penalties (sometimes the entire cost) for drugs not on the formulary.

Many health plans/M+C organizations make periodic changes to formularies or the items on preferred lists, often convening meetings of their pharmacy and therapeutics committees several times a year to add and remove items from the formulary or preferred list. When they enroll in a M+C plan, beneficiaries may not be aware that changes to formularies or preferred lists are likely to occur during the contract year.

Every health plan/M+C organization that covers outpatient prescription drug benefits (those not covered under the original Medicare fee-for-service program) must provide notice in its Evidence of Coverage (EOC) whether it uses a formulary or preferred list. If it uses formularies or preferred lists, the notice shall include:

- An explanation of what a formulary is;

- A statement that the formulary (or drugs on the preferred list) may change during the contract year;

- An estimate of how often the health plan/M+C organization reviews the contents of the formulary and makes changes based upon that review;

- A description of any process by which a prescribing provider may obtain authorization for a non-formulary or non-preferred list drug to be furnished under the same terms and conditions as drugs on the formulary or preferred list; and

- A statement that members may use health plan/M+C organization grievance and appeals process if they have complaints about the formulary or its administration.

In addition, health plans/M+C organizations that use formularies or preferred lists must disclose whether specific drugs are on the health plan/M+C organizations' formularies or preferred lists when enrollees or potential enrollees make telephone or other inquiries.

With respect to pre-enrollment marketing materials that describe plan benefits, health plans/M+C organizations must disclose whether a formulary or preferred list is used and that the formulary or list may change during the contract year and provide a contact number that the beneficiary can call for more information. This policy will be effective beginning in contract year 2001 and will be incorporated into the Model EOC for 2001.

40.4 - Conducting Outreach to Dual Eligible Membership

(Rev. 15, 09-27-02)

A number of M+C plan members are, due to financial status, eligible for State financial assistance through State Medicaid Programs. This assistance provides them an array of financial savings ranging from partial payment of Medicare Part B premiums to full payment of Medicare premiums and other plan cost sharing. Historically, some of those eligible do not apply for these State savings programs because:

1. The individuals equate Medicaid with Welfare and associate a social stigma to the terms;

2. They are not aware of the savings that are available;

3. They do not understand the eligibility requirements; or

4. They find the process sometimes complex and difficult to understand.

Some M+C organizations choose to conduct outreach to their M+C members to educate them and to assist them in applying for these savings programs. This may be especially true because CMS capitates M+C organizations at a higher rate for some dual eligible members.[12] The CMS encourages but does not require M+C organizations to assist their members with applying for State financial assistance because of the potential benefits to both the members and to the M+C organizations.

This section instructs M+C organizations in outreach program requirements and the process for submitting those programs and member materials (e.g. letters, call scripts,

etc.) to CMS for approval. It also provides CMS staff with operating procedures for reviewing and approving the outreach programs.

40.4.1 - General Guidance on Dual Eligibility

(Rev. 28, 08-01-03)

There are several categories of dual eligibility, each having specific income requirements and providing different levels of financial assistance to those who qualify at that level. The categories are outlined in the following chart:

Additional information is available at http://www.cms.hhs.gov/medicaid/. Income Requirements for Hawaii and Alaska specifically noted. Resource and Income Limits shown below may vary by state; contact the state for specific resource amounts.

Eligibility Category	Monthly Income Requirements	Medicaid Benefits	Provider	Medicaid Liability for Services
QMB only Qualified Medicare Beneficiary without other Medicaid	$*769* – individual $*1,030* – couple Alaska: $*955* –individual $*1,282* – couple Hawaii: $*881* – individual $*1,182* – couple	Medicare premiums, deductibles, and coinsurance. No Medicaid services.	Medicare	QMB rates for Medicare deductibles and coinsurance
QMB Plus Qualified Medicare Beneficiary with Full Medicaid	$*769* – individual $*1,030* – couple Alaska: $*944* – individual $*1,282* – couple Hawaii: $*881* – individual $*1,182* – couple	Medicare premiums, deductibles, and coinsurance. Medicaid services.	Medicare Medicaid	QMB rates for Medicare deductibles and coinsurance Medicaid rates for Medicaid services only.
SLMB only Specified Low-Income Medicare Beneficiary without other Medicaid	$*918* – individual $*1,232* – couple Alaska: $*1,141* – individual $*1,534* – couple Hawaii:	Medicare Part B premiums. No Medicaid services.	Medicare	No liability for Medicare deductibles and coinsurance.

	$*1,053* – individual $*1,414* – couple			
SLMB Plus Specified Low-Income Medicare Beneficiary with Full Medicaid	$*918* – individual $*1,232* – couple Alaska: $*1,141* – individual $*1,534* – couple Hawaii: $*1,053* – individual $*1,414* – couple	Medicare Part B premiums. Medicaid services.	Medicare Medicaid	No liability for Medicare deductibles and coinsurance. Difference between Medicare payment and Medicaid rates for Medicaid services.
QI-1 Qualifying Individuals - 1	$*1,031* – individual $*1,384* – couple Alaska: $*1,282* – individual $*1,725* – couple Hawaii: $*1,183* – individual $*1,589* – couple	Medicare Part B premium.	Medicare	No liability for Medicare deductibles and coinsurance.
QDWI Qualified Disabled and Working Individuals	$*3,078* – individual $*4,125* – couple Alaska: $*3,822* – individual $*5,132* – couple Hawaii: $*3,528* – individual $*4,732* – couple	Medicare Part A premium.	Medicare	No liability for Medicare deductibles and coinsurance.

40.4.2 - Guidelines for Outreach Program

(Rev. 28, 08-01-03)

In order to assure CMS that M+C organizations' outreach programs effectively assist members while protecting them from undue pressures or privacy violations, M+C organizations[13] must adhere to the following guidance.

The M+C organizations MUST:

1. Provide outreach to all levels of dual eligibles, including those levels that do not provide M+C organizations with additional capitation amounts from CMS. All

outreach materials (e.g., member letters (see §40.4.5 for a model Direct Mail Letter), telephone scripts) must include eligibility information that includes *the* QI-1 *level*. [See footnote 12 for clarification.]

2. Clarify in outreach materials that the member may voluntarily offer information, including financial information, but that the member is not obligated to provide this information.

3. Clarify in outreach materials and discussions with members that the member's failure to provide information will in no way adversely affect the beneficiary's membership in his or her health plan.

4. State in materials and discussions with members that the M+C organization will not share the information with any other entity not directly associated with determining eligibility or under contract to participate in the outreach process.

5. Clarify in outreach materials that the M+C organization is only providing an initial eligibility screening and that only the appropriate State Agency can make a final eligibility determination.

6. Provide guidance to a member on how to proceed with the application process even if the M+C organization's screening process indicates that the member is probably not eligible for assistance under any of the dual eligibility programs.

7. Provide adequate training to staff conducting the outreach. If the M+C organization subcontracts this effort to another entity, it must ensure that the subcontractor's staff is adequately trained to provide outreach.

8. Include alternate sources of information in *all* outreach materials. Member letters and/or brochures that contain outreach information telephone numbers must also include the telephone number for the State Health Insurance Assistance Program (SHIP) and the appropriate State Agency. Outreach materials may also include the telephone number for the Medicare Service Center (1-800-MEDICARE).

9. Include privacy guidelines in outreach materials, telephone scripts, and internal processes and/or contracts with entities performing outreach for the M+C organization. Contractual privacy guidelines must clearly state that all financial information collected from members of the M+C organization will not be used for any other purpose by the entity collecting the data. Privacy guidelines must also state that entities involved in the outreach will not share member information with anyone not involved in the outreach process.

10. Ensure that contracts with entities taking part in some aspect of outreach activities meet M+C Administrative Contracting requirements listed in the Medicare Managed Care Manual Chapter 11, §100.5.

11. Work closely with CMS' regional office staff during the outreach submission and review process so that CMS can work cooperatively with stakeholders (e.g., SHIPs, State Agency) to ensure better education and preparation prior to the outreach process initiation.

12. *Develop contacts with the appropriate State Agency/agencies that determine eligibility and handle eligibility appeals for Medicare Savings Programs.*

The M+C organizations MAY:

1. Conduct outreach for only a portion of its plan membership. Selection of the focus population may be based upon demographic data and/or may focus on a specific geographic area. However, the organizations must provide outreach to all individuals within those pre-identified population segments. Additionally, if the organization receives an inquiry from a Plan member not previously identified in the targeted group, it must provide assistance to that member as if he or she had been included on the outreach list.

2. Provide hands-on assistance to the member in completing all necessary applications for financial assistance including submitting the paperwork to the appropriate State office. This assistance can be in the member's home only if the member requests such a visit.

3. Use the "Authorization to Represent" limited to the specific purposes of completing and submitting paperwork on behalf of the member, discussing the member's case with case workers, representing the member in cases of appeal, and gather information from and on behalf of the Plan member. The "Authorization to Represent" form must specify that the authorization is limited to securing benefits under "the Medicare savings program" or "the Medicaid Program" and cannot extend to other programs unless agreed upon and noted by the member. "Authorization to Represent" shall not give the outreach specialist the authority to sign any documents on behalf of the member nor make any enrollment decisions for the member.

4. Follow-up with members who do not respond to the initial member letter. This follow-up may be in the form of a second and/or third letter or telephone calls. If the member does not respond to the third effort, the M+C organization *must* refrain from contacting the member for at least six months following the last outreach attempt. *If the member requests to be removed from the contact list, the M+C organization may not provide further outreach unless the member requests it.*

5. Provide assistance to members reapplying for financial benefits if and when required to do so by the State Agency.

6. Subcontract all outreach efforts to another entity or entities. In such cases, while the M+C organization retains all responsibility for meeting CMS' requirements, it must still submit all documentation to CMS for approval including contracts held by the subcontractor with all entities related to the program. The M+C organization must also coordinate changes and revisions between the subcontractor and CMS.

The M+C organizations Shall NOT:

1. Conduct door-to-door solicitation or outreach prior to receiving an invitation from the member to provide assistance in his or her home.

2. Share any member information, financial or otherwise, with any entity not directly involved in the outreach process.

3. Store or use member financial information for any purpose other than the initial screening eligibility, the submission and follow-up of an application for benefits, for recertification purposes, and as required by law.

4. Contact any member who has refused outreach assistance or who has not responded to the telephone call or follow-up letter until at least six months following the last outreach attempt.

5. *Contact the member who has requested to be removed from the outreach list.*

6. Infer in any written materials or other contact with the member that the organization has the authority to determine the member's eligibility for state assistance programs.

40.4.3 - Submission Requirements

(Rev. 28, 08-01-03)

To facilitate CMS' review of outreach programs, an M+C organization must submit one copy of the *materials* listed below to its Central Office Plan Manager, one copy to the Regional Office Plan Manager, *one electronic copy to the Dual Eligibility Outreach Product Consistency Team (PCT),* [15] *and the Regional Office Plan Manager.*

1. Detailed description of each step in the outreach process and the entity responsible for each step. (CMS recommends a flow chart showing the result of each action.)

2. Timeline showing the proposed dates of outreach activities, the number of members involved in each activity, and the service area (e.g., county) included in the activities. This is to allow CMS to more accurately coordinate outreach activities with its partners (e.g., SHIP, State Agencies).

3. *Executed c*ontracts with all external entities involved in the outreach process. This includes contracts with any subcontractors taking part in the activities.

4. *Supporting documentation from the appropriate State Agency providing specific state income requirements for each savings program level, and names and contacts within the appropriate State Agency/agencies.*

5. Outreach letters and other materials (e.g., brochures*, Authorization to Represent form*) going to plan members.

6. Internal training programs the organization is using to educate staff involved in outreach.

7. Telephone scripts or other outreach assistance scripts that will guide representatives in answering members' questions or discussing the assistance available to them. Such scripts must include a privacy statement clarifying that the member is not required to provide any information to the representative and that the information provided will in no way affect the beneficiary's membership in the plan.

8. Internal plan for protecting the confidentiality of the member's financial or other personal information gathered in the outreach process.

In some instances, an M+C organization may chose to submit an outreach proposal that CMS has already approved for use by another M+C organization. This is common when an M+C organization is part of a national organization with multiple contracts, each of which is conducting its own outreach. This is also common when a subcontracting entity designs and conducts the outreach. These subcontractors often seek to contract with multiple M+C organizations and conduct the same outreach programs for each of their clients.

If an M+C organization submits an outreach proposal that (a) CMS previously approved on or after April 1, 2002; (b) That CMS approved within the twelve months prior to the submission; and (c) That does not contain substantive changes [14] to qualify it as an "initial" proposal, the M+C organization must submit the items listed above (1 - *8*) in addition to the following:

> An attestation from either the M+C organization or its contracted outreach vendor stating (a) That the proposal has been approved by CMS, (b) The date of that approval, and (c) That the new submission does not contain substantive changes to the approved program.

Section 40.4.4 contains a description of CMS' review process and time frames for both initial and previously approved proposals.

40.4.4 - CMS Review/Approval Process

(Rev. 28, 08-01-03)

NOTE: The CMS review process for new outreach proposals differs from the review process or previously approved outreach proposals. The processes for both submissions are stated below.

Reviewing New Outreach Programs

1. The M+C organization is responsible for submitting the outreach proposal to CMS and working with CMS through the review and approval process even if a subcontractor developed the proposal. The CMS will hold the M+C organization fully responsible for all the provisions of the outreach program and for assuring the members of their rights and protections outlined in the M+C program regulations.

2. In that CMS considers outreach materials to be a form of marketing, CMS will review outreach proposals according to current time frames for reviewing marketing material. The agency will conduct its initial review and provide comments to the M+C organization within 45 days of receipt of a new (not previously approved) proposal.

3. As noted in §40.4.3, M+C organizations must submit one complete copy of the materials listed in §40.4.3 to the CMS Central Office Plan Manager, a second copy of the same materials to the CMS Regional Office Plan Manager, and an electronic copy of the materials to the Dual Eligibility Outreach (PCT)[15]. *If a proposal incorporates states in regions other than those represented above, the PCT ensures that the appropriate Regional Office Plan Manager receives a copy of the proposal for comment from the National Account Representative (NAR) for the state(s).*

   The Dual Eligibility PCT will review all the enclosed documentation in conjunction with the Plan Managers and will provide comments to the Central and Regional Office Plan Managers. The Regional Office Plan Manager will relay CMS comments back to the M+C organization will gather revisions (when necessary) and will finish the review and approval process based upon the M+C organization's revisions.

4. The Regional Office Plan Manager will share outreach materials with the appropriate *NARS and state representatives. The NARS and state representatives should, at a minimum, share the member letters with the* State agency as a way to verify the accuracy of the information contained in the proposal and to receive input from state partners.

5. Upon final approval of the proposal and outreach materials, the Regional Office Plan Manager will send an approval letter to the M+C organization.

6. The Regional *Office* will then contact its partners (SHIPs, State Medicaid Offices, etc.) to notify them of the outreach effort and possible increase in beneficiary inquiries. The Regional office will share copies of outreach letters with the State Agencies to prepare them for incoming questions.

Reviewing Previously Approved Outreach Programs

If an M+C organization submits an outreach proposal that CMS has already approved and that does not contain substantive changes (outlined in §40.4.3), then the CMS Regional Plan Manager*, in conjunction with the appropriate NARs,* will only review the targeted membership information (audience number and outreach dates), the contract(s) between the M+C organization and its outreach subcontractor(s), the updates to benefit levels and income and resource criteria, and the attestation. The CMS will respond to the M+C organization within the 10-day time frame CMS has established for reviewing standardized marketing materials. The CMS' Regional office will file the outreach proposal for future reference. The CMS recognizes that the M+C organization will have to make simple periodic changes to their outreach programs in order to update minimum income levels, etc. As stated previously (*in footnote 14*), CMS does not consider these updates to be "substantive changes" in that they do not prompt a full review of an outreach proposal. However, the M+C organization is still responsible for submitting such changes to the appropriate CMS regional office for marketing review to ensure accuracy of such changes.

If the M+C organization wishes to make substantive changes to the outreach process, it must submit those changes to the appropriate CMS Central Office and Regional Office Plan Managers for review through the PCT according to the review process above.

40.4.5 - Model Direct Mail Letter

(Rev. 28, 08-01-03)

(Data valid for 200*3*)

August 25, 200*3*

Mr. Frank Smith
123 Maple Lane
Anywhere, USA 12345

Dear Mr. Smith,

Did you know you may be able to save up to *$704.40* a year on Medicare expenses?

States have programs that pay some or all of Medicare premiums, may also pay Medicare deductibles and coinsurance, and Medicare health plan premiums. These programs are administered as part of the State Medical Assistance Program.

If you answer "yes" to ALL three of these questions, then you may qualify for Savings for Medicare Beneficiaries.

- Do you have Medicare Part A, also known as hospital insurance? If you are eligible for Medicare Part A, but do not have it because you cannot afford it, you may still qualify because there is a program that will pay the Medicare Part A premium.

- Are you an individual with a monthly income of less than *$1,031* or a couple with a monthly income of less than *$1,384?*

- Are you an individual with savings of $4,000 or less or a couple with savings of $6,000 or less? Savings include things like money in a checking account or savings account, stocks, or bonds. When you are figuring out your savings, do not include your home, a car, burial plots, up to $1,500 for burial expenses, furniture, or $1,500 worth of life insurance.

If you have a disability and lost your Medicare because you returned to work and are eligible to purchase Medicare Part A benefits, you should also apply. To qualify, you must be an individual with a monthly income of less than $3,078 and resources of $4,000 or less. Or, you must be a couple with a monthly income of less than $4,125 and resources of $6,000* or less.*

** Individual states may have more generous requirements.*

Enclosed is a brochure that gives you more information about the programs that can help you save on your medical expenses, information on who qualifies, and how to apply for the programs.

I hope you will call me between 9 a.m. and 5 p.m. Monday through Friday at (your phone number here) for more information or for help joining one of these programs. All information that you share will only be used to determine if you may be able to get help with your medical expenses. I will not share the information with anyone else. I encourage you to call to see if you can receive help with your medical expenses, but the choice is yours. You are not required to call. If you like, you can also receive information about the programs by calling a representative of the State Health Insurance Assistance Program at XXX or a State representative at XXXX. Deaf or hearing-impaired people who use a TTY/TDD can call Medicare's national help line at 1-800-486-2048. When you call, ask about programs that can help with Medicare expenses.

40.5 - Specific Guidance for the Standardized Summary of Benefits (SB)

(Rev. 20, 04-04-03)

The standardized Summary of Benefits (SB) is a stand-alone marketing document that is generated from the Plan Benefit Package. It is the primary pre-enrollment document used by M+C organizations to inform potential Medicare beneficiaries of plan benefit packages offered by M+C organizations.

40.5.1 - Summary of Benefits for Medicare+Choice Organizations

(Rev. 28, 08-01-03)

Medicare+Choice organizations and Demonstration projects are required to use a standardized SB.

A. General Instructions

1. *M+C organizations must adhere to the language and format of the standardized SB and are only permitted to make changes if approved by CMS. Changes in the language and format of the SB template will result in the disapproval or delayed approval of the SB.*

2. *The title "Summary of Benefits" must appear on the cover page of the document.*

3. *All three sections of the SB must be provided together as one document and may not be bound separately or placed in a folder in separate sections. M+C organizations may also describe several plans in the same SB package by displaying them in separate columns in the comparison matrix section of the SB.*

4. *Front and back cover pages are acceptable.*

5. *Printing font size of 12-point or larger must be used for the SB (including footnotes).* ***NOTE:*** *Since sections 1 and 2 will not be generated from the PBP in 12-point font, the M+C organization should change the font to ensure that the font size is 12 point. M+C organizations may enlarge the font size and also use bold or capitalized text to aid in readability, provided that these changes do not steer beneficiaries to, or away from any benefit items or interfere with the legibility of the document.*

6. *Colors and shading techniques, while permitted, must not direct a beneficiary to or away from any benefit items and must not interfere with the legibility of the document. There is no requirement regarding the type of paper used.*

7. *It is acceptable to print the SB in either portrait or landscape page format.*

8. *It is acceptable for M+C organizations with multiple plans and PBPs (separate ACRPs) to include more than one plan in the benefit comparison matrix (section 2). However, since the PBP will only print section 1 and 2 reports for one plan, the M+C organizations will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format.*

9. *It is acceptable for M+C organizations to display more than one plan together in the same columns of the benefit comparison matrix, provided all of the benefits are the same and only the service areas are different. Plans may identify the service areas at the top of the plan column of section 2.* ***NOTE:*** *if anything beyond the service area is different, the plans must be displayed separately.*

10. *If the SB includes only one of several plans offered, the availability of other plans must be noted in the Annual Notice of Change (ANOC). If the M+C organization lists more than one plan offering, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB.*

11. *If an M+C organization wants to include mandatory supplemental benefits beyond those benefits found in the benefit comparison matrix, the M+C organization must place the information in section 3 of the SB. The M+C organization must include a brief description of the benefits and any copay requirements.*

12. *If an M+C organization includes additional information about covered benefits in section 3, the M+C organization may include a page reference to this information in the appropriate box in the benefit comparison matrix using the following sentence: "See page___ for additional information about (Enter the benefit category exactly as it appears in the left column)."*

13. *M+C organizations may include additional information about covered benefits in a separate flyer or other material and mail this with the standardized SB and the Annual Notice of Change Letter.*

14. *Enrollees whose source of enrollment is through an employer-sponsored group are not currently included in the mandated use of the standardized SB for either annual notification or initial marketing purposes.*

B. Section 1 - Beneficary Information Section

1. *This section is incorporated into your SB exactly as it is generated by the PBP.* ***NOTE:*** *M+C organizations have the option of indicating at the top of this section a geographic name, for example, "Southern Florida." If used, the geographic name must match the geographic label indicated in the Health Plan Management System (HPMS).*

2. *Section 1, as generated by the PBP, will include the applicable H number and plan number at the top of the document. M+C organizations must delete this information.*

3. *The fourth paragraph (How can I compare my options?) contains a sentence "We also offer additional benefits, which may change from year to year." If this is not applicable to your plan, you must remove this sentence.*

4. *The second question and answer in section 1 includes the plan's service area; the PBP will generate a list of counties, with an * indicating those counties that are partial counties. The M+C organization may list the zip codes of these counties in this section or provide a cross-reference in section 3 and list the zip codes here. The M+C organization must also explain in section 1 that the * indicates a partial county.*

5. *The second question and answer in section 1 lists the plan's service area, but does not indicate that the information listed represents counties. Therefore, the M+C organization must amend the SB so that the answer reads, "The service area for this plan includes the following counties: [list of counties automatically generated by the PBP].*

6. *The last sentence in section 1 on page 2 states, "If you have special needs, this document may be available in other formats." M+C organizations contracting with CMS are obligated to follow the regulatory requirements of the American with Disabilities Act and the Civil Rights Act of 1964. Compliance with these requirements satisfies the intent of the above referenced SB sentence. No additional requirements are imposed by the above referenced SB sentence.*

C. Section 2 - Benefit Comparison Matrix

The SB benefit comparison matrix will be generated by the PBP in chart format with the required language. Therefore, the information included in the PBP must first be correct in order for the SB comparison matrix to be correct. M+C organizations should review the comparison matrix to ensure that all of the information presented is correct. Information presented in the benefit comparison matrix must match the information presented in the PBP, with the exception of the permitted and/or necessary changes discussed below. If any changes are required, the M+C organization must make these changes in the PBP prior to the deadline date for submission of the ACRP, generate a revised SB benefit comparison matrix, and include this matrix in its SB. The CMS reviewers will have the benefit comparison matrix that is generated by the PBP and will compare this with the matrix provided as part of the plan's SB. Any discrepancies between the matrix generated by CMS and that provided by the plan (with the exception of those permitted below) will result in disapproval of the SB.

D. Section 3 - Plan Specific Features

This section is limited to a maximum of four pages of promotional text and graphics and is not standardized with regard to format or content. The 4-page limit means that the information is limited to four single-sided pages or 2 double-sided pages. ***However, there are two exceptions to this limit:***

1. *PPOs will be allowed to use up to two more pages (i.e., for a total of up to six pages) to describe out of network benefits or to describe out of network benefits with the in-network benefits that are described in section 3; and*

2. *When an M+C organization is translating the SB to a foreign language, it may add pages as necessary to ensure the translation matches the English language version.*

Section 3 is used by the M+C organization to describe special features of the M+C organization beyond information contained in sections 1 and 2 of the SB. Section 3 may contain non-standardized language, graphics, pictures, maps, etc.

The M+C organizations may use this section to further describe mandatory and optional supplemental benefits that appear in the benefit comparison matrix. If an M+C organization chooses to do this, they may reference the information in the relevant section of the benefit comparison matrix using the following sentence: "See page___ for additional information about (Enter the benefit category exactly as it appears in the left column.)"

E. Permitted Changes To SB Language and Format

M+C organizations are only permitted to make changes to the benefit matrix or Hard Copy Summary of Benefits on a limited basis. ***Any changes*** *must be approved by CMS. Please refer to the Requests to Change Hard Copy Summary of Benefits for further detail.*

F. Footnotes

The comparison matrix generated by the PBP will not contain the required footnotes. Therefore, the M+C organization must include the following footnotes provided below. Please note that the footnote number must appear in the text of the column and the footnote must appear at the bottom of each page.

NOTE: *For review purposes, the M+C organization can list all of the footnotes at the end of section 2, but the final proof copy must include the footnotes at the appropriate points in the text. If the M+C organization chooses this option, the M+C organization must notify the CMS Regional Office conducting the review and must indicate in the SB where the footnotes will actually appear in the final printed version.*

1. *Each year, you pay a total of one $100 deductible.*

This footnote must be referenced after every statement in the Original Medicare (OM) column that describes the required Medicare coinsurance, e.g., "You pay 20% of Medicare approved amounts." Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. This footnote must also appear at the bottom of each page.

2. *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.*

   This footnote must be referenced, where applicable, after every statement in the OM column that describes Medicare benefits and after footnote (1). The text of this footnote must appear at the bottom of each page.

3. *A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.*

4. *This footnote must be referenced after the words "benefit period" in the OM column describing Inpatient Hospital Care and Skilled Nursing Facility and the text of this footnote must appear at the bottom of the page on which these benefits are described. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column.*

Lifetime reserve days can only be used once.

This footnote must be referenced after the statement, "Days 91-150: $ (The Medicare amount may change each year) each lifetime reserve days" in the OM column describing Inpatient Hospital Care. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. The text of this footnote must appear at the bottom of the page on which these benefits are described.

40.5.2 -Summary of Benefits for Cost Plans

(Rev. 20, 04-04-03)

Cost plans are not required to use the standardized Summary of Benefits, however they are required to provide members with an SB. If a cost plan intends to have the plan appear in Medicare Health Plan Compare and Medicare Personal Plan Finder, it will need to complete the Plan Benefit Package (PBP) to create a standardized SB. Cost plans that create a standardized SB should follow all instructions below.

Cost plans should follow all instructions outlined in §40.5.1 for M+C organizations. In addition, the following instructions are specific to cost plans.

A. General Instructions

1. *The benefit description column and Original Medicare column must remain unchanged.*

2. *All sentences in the plan column of the matrix must be completed with applicable copays or coinsurance amounts.*

3. *Additional instructions provided in italicized text and in parentheses should be removed from the Summary of Benefits prior to submitting the document to CMS for review.*

4. *Unless otherwise indicated, cost plans should choose all of the applicable sentences in each category to describe their benefits.*

B. Section 1- Beneficiary Information Section

For cost plans that are "closed" to new enrollment, the pre-enrollment language in section 1 will not apply. Therefore, these cost plans should include the following disclaimer in their ANOC. Any additional information regarding the contractor's "closed status" should also be included in the cover letter.

> *The CMS requires the Summary of Benefits (SB) to be used in both pre-enrollment and annual notice of change (ANOC) functions. Plan member receiving the SB should disregard all pre-enrollment language.*

C. Section 2 - Benefit Comparison Matrix

Cost plans may include the following footnote on each page of the benefit comparison matrix. The text of the footnote should appear at the bottom of every page.

> *If you go to a provider outside of [insert name of plan] who accepts Medicare patients, your coverage would be the same as Original Medicare. Original Medicare deductibles and coinsurance apply.*

50 - Guidelines for Promotional Activities

(Rev. 9, 04-01-02)

This section reviews the use of promotional activities relating to the enrollment and retention of members. Section 50.1 of this section provides general guidance about promotional activities, while §50.2 provides specific guidance for provider promotional activities. Section §50.3 describes CMS' policy with respect to the use of independent

insurance agents for marketing purposes. Section 50.4 answers some frequently asked questions regarding all aspects of promotional activities. Definition and policy changes in this section are a result of compliance with directives from the Office of Inspector General regarding monitoring of Medicare managed care operations under several statutes that prohibit unlawful influence/inducement of Medicare beneficiaries.

50.1 - General Guidance About Promotional Activities

(Rev. 9, 04-01-02)

Promotional activities (including provider promotional activities) must conform to the requirements of §§1128A(a)(5) and 1128B(b) of the Act. Section 1128A(a)(5) of the Act provides for a civil monetary penalty against a person or entity that offers or transfers remuneration to a Medicare or Medicaid eligible individual that the person or entity knows or should know is likely to influence such eligible individual to receive or order services from a particular provider. Section 1128B(b) of the Act, the Medicare and Medicaid anti-kickback statute, prohibits the offering or giving of remuneration to induce the referral of a Medicare or Medicaid beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare or Medicaid programs. Additional prohibitions on the offering of monetary rebates or inducements of any sort to enrollees are contained in §1854(d) of the Act.

50.1.1 - Nominal Gifts

(Rev. 5, 01-02-02)

Many health plans/M+C organizations offer gifts to potential enrollees if they attend a marketing presentation. This is permitted as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the health plan/M+C organization. Nominal value is defined as an item worth $15 or less, based upon the retail purchase price of the item. Local Medicare fee-for-service fiscal intermediary and/or carrier charge listings can be used to determine the value of medical services, examinations, laboratory tests, etc., associated with nominal value determinations in marketing scenarios. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount. The dollar amount associated with the definition will be periodically reassessed by CMS. An organization may offer a prize of over $15 to the general public (for example, a $1,000 sweepstakes on its corporate Web site) as long as the prize is offered to the general public and not just to Medicare beneficiaries. When the whole company is offering a prize to individuals well beyond only Medicare individuals, and that prize does not relate to a specific inducement to enroll in company products, the company should not exclude anyone with Medicare from being able to win the prize.

50.1.2 - Referral Programs

(Rev. 28, 08-01-03)

The following general guidelines apply to referral programs under which health plans/M+C organizations solicit leads from members of new enrollees. These include gifts that would be used to thank members for devoting time to encouraging enrollment. Gifts for referrals must be available to all members and cannot be conditioned on actual enrollment.

- *Health plans/M+C organizations may not use cash promotions as part of a referral program.*

- *Health plans/M+C organizations may offer thank you gifts of less than $15 nominal value (e.g., thank you note, calendar, pen, key chain) when an enrollee responds to a health plan/M+C organization solicitation for referrals. These thank you gifts are limited to one gift per member, per year.*

- *A letter sent from the health plan/M+C organization to members soliciting leads cannot announce that a gift will be offered for a referral.*

50.1.3 - Health Fairs and Health Promotional Events

(Rev. 9, 04-01-02)

Many health plans/M+C organizations are interested in offering health fairs or social events that promote health awareness and a sense of belonging among seniors. Health plans/M+C organizations may participate in such events as either the sole sponsor of the event or as a member of a multiple-sponsor event. Application of the following CMS policies to the condition of sponsorship is indicated by **(Sole-Sponsor)** for sole sponsor events, **(Multiple-Sponsor)** for multiple-sponsor events, and **(Both)** where the policy applies to both single and multiple sponsor events. If an audience is comprised of the general public as well as Medicare beneficiaries, the following policies apply to the entire audience:

- Such events should be social and should not include a sales presentation. (Both) Response by a health plan/M+C organization representative to questions will not be considered a sales presentation if no enrollment form is accepted at the event. (Both)

- Advertisements for the event can be distributed to both members and non-members. (Both)

- The value of any give-away or free items (e.g., food, entertainment, speaker) cannot exceed $15 per attending person. For planning purposes, event budgets can

be based on projected attendance. The cost of overhead for the event (e.g., room rental) is not included in the $15 limit. (Both)

- Pre-enrollment advertising materials (including enrollment forms) can be made available as long as enrollments are not accepted at the event. (Both)

- If offered, door prizes/raffles cannot exceed the $15 limit. (Sole-Sponsor) However, door prizes/raffles can exceed the $15 limit if a health plan/M+C organization contributes to a pool of cash for prizes or contributes to a pool of prizes such that the prize(s) is not individually identified with the health plan/M+C organization, but is identified with a list of contributors. A jointly-sponsored event may consist of the health plan/M+C organization and one or more sponsor participants who are not contracting providers with the health plan/M+C organization. A health plan/M+C organization may also contribute cash toward prize money to a foundation or another entity sponsoring the event. For example: A radio station, along with many sponsors, puts together a seniors fair. Anyone who attends may register for the door prize: a get-away weekend. The health plan/M+C organization may participate in the fair, contribute to the door prize, and permit attendees to register for the prize at its booth (as well as other sponsor booths). However, the health plan/M+C organization cannot claim to be the sole donor of the prize. It must be clear that the prize is attached to the seniors fair. No sales presentation may be made at the event. (Multiple-Sponsor)

50.1.3.1 - Employer Group Health Fairs

(Rev. 9, 04-01-02)

Enrollment restrictions (i.e., no sales presentations can be made or enrollment applications accepted at the meeting) do not apply to health fairs or other promotional events sponsored by an employer group or labor organization so long as the following requirements are met:

1. The meeting must be held solely for retirees and any active employees (and their spouses/interested decision makers) from the employer/labor organization. No "general public" persons may be solicited or invited to attend the meeting; and

2. The meeting may not be announced via "public media" vehicles. Potential employer group/labor organization retirees must be notified of the meeting by individual notification or by company/labor organization sponsored media such as a newsletter or similar targeted mailing/vehicle.

50.1.3.2 - CMS-Sponsored Health Information Fairs

(Rev. 9, 04-01-02)

The Centers for Medicare & Medicaid Services is required to conduct a nationally coordinated education and information campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under the law for enrolling in Medicare+Choice plans. One of the coordinated education and information campaign activities is CMS sponsorship of Medicare+Choice Health Information Fairs.[16] While most CMS-sponsored M+C Health Fairs will be conducted immediately before and during the month of November each year (the Annual Election Period), occasionally CMS will sponsor Health Fairs as early as September and other times of the year. The following rules and procedures apply to CMS-sponsored Health Fairs, whenever they occur.

CMS will invite the M+C organizations to participate in the planning of local Health Fairs. M+C organization participation is optional, but it is important to get current contractors to the planning table. It is imperative that all CMS regions are consistent in applying participation guidelines at these **CMS-Sponsored** Health Fairs. Below are the guidelines. The CMS retains the right to modify these guidelines if CMS encounters a new situation that must be addressed.

50.1.3.3 - Allowable Actions for Medicare + Choice Organizations

(Rev. 28, 08-01-03)

Medicare + Choice Organizations may do the following:

- Assist in the planning of local Health Fairs;
- Distribute health plan brochures and *application forms*, while at the Health Fair.[17] They may also include in their handouts a reply card which may be given to interested beneficiaries for return to the organization via mail;
- Have a booth at the Health Fair;
- Distribute items with a total retail value of no more than $15. These items MUST be offered to everyone, (e.g., organizations can not give gifts to only those individuals who show interest;
- Have any personnel present (i.e., marketing personnel, customer service personnel) as long as they adhere to these guidelines;
- Contribute funding for any Health Fair costs (i.e., purchasing of food; drawings, raffles, or door prizes for attendees which exceed the $15 nominal value

requirement) as long as the recognition of the donation is to a number of entities (not just one particular M+C organization); and

- Market multiple lines of business in Medicare + Choice.

Medicare+Choice Organizations may not do the following:

- Give sales presentations;
- Collect enrollment applications. (Although *application forms* may be distributed, they may not be collected during CMS-sponsored Health Fairs);
- Collect names/addresses of potential enrollees. However, as noted above, they may distribute *application forms* and reply cards;
- Compare their benefits against other health plans. However, they may use comparative information which has been created by CMS (such as information from CMS' Web site) or information/materials which have been approved by CMS (i.e. the standardized Summary of Benefits);
- Third party created materials may not be used, unless they have been approved by CMS in advance; and
- Give individual gifts with a retail value of more than $15.00.

50.2 - Specific Guidance About Provider Promotional Activities

(Rev. 20, 04-04-03)

Some health plans/M+C organizations use their providers to help them market their Medicare product. As used in this *chapter*, the term "provider" means all Medicare health plan/M+C organization contracting health care delivery network members; e.g., physicians, hospitals, etc. The purpose of this section is to specify what practices in this area meet both CMS requirements and the needs of the health plans/M+C organizations with respect to entities considered providers by health plans/MCOs.

The CMS is concerned with provider marketing for the following reasons:

- Providers are usually not fully aware of all health plan/M+C organization benefits and costs; and
- A provider may confuse the beneficiary if the provider is perceived as acting as an agent of the health plan/M+C organization vs. acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a health plan/M+C organization representative since they know their patients' health status. Desires to either reduce out-

of-pocket costs for their sickest patients, or to financially gain by enrolling their healthy patients may result in recommendations that do not address all of the concerns or needs of a potential health plan/M+C organization enrollee.

There are some permissible *delegated* provider marketing activities, however. Listed below are some requirements for these, and the reasons they are permitted:

1. **Health Fairs** - At health fairs, provider groups and individual providers can give out health plan/M+C organization brochures including *enrollment applications*. Because they may not be fully aware of all benefits and costs of the various health plans/M+C organizations, providers or their representatives cannot compare benefits among health plans/M+C organizations in this setting. In addition, applications may not be taken at health fairs. (See the discussion of health fairs and health promotion events in section 1 above.)

2. **Provider Office Activities and Materials** - In their own offices, provider groups and individual providers can give out health plan/M+C organization brochures, and posters announcing health plan/M+C organization affiliation (all of which must be exclusive of applications). Providers, their representatives and qualified health plan/M+C organization (marketing) representatives are all prohibited from taking applications in the place where health care is delivered, such as provider offices or hospital wards. This is to prevent Medicare beneficiaries from experiencing inappropriate pressure to enroll at the time that health care is being delivered. Providers cannot offer inducements to persuade beneficiaries to join health plans/M+C organizations or to steer beneficiaries to a specific health plan/M+C organization.

   In addition, providers cannot offer anything of value to induce health plan/M+C organization enrollees to select them as their provider. When patients seek information or advice from their own physician regarding their Medicare options, physicians may engage in this discussion. Because physicians are usually not fully aware of all health plan/M+C organization or original Medicare benefits and costs, they are advised to additionally refer their patient to other sources of information, such as 1-800-MEDICARE, the State Health Insurance Assistance Program, and/or specific health plan/M+C organization marketing representatives. Additional information can also be found on CMS' Web site, http:www.medicare.gov. Physicians are permitted to printout and share information with patients from CMS' Web site.

3. **Health Plan/M+C organization and Provider Cosponsorships** - Providers and provider groups can co-sponsor an event, e.g., an open house or a health fair with a health plan/M+C organization. Providers and provider groups and health plans/M+C organizations can cooperatively market and advertise by such means as TV, radio, direct mail, testimonials, posters, fliers and print ads. All marketing materials describing the health plan/M+C organization in any way must get prior approval, should have the health plan's/M+C organization's name or logo on them

as well as the provider's/provider group's name or logo, and must follow all of the rules in Chapter 3 - Guidelines for Advertising Materials. All materials mentioning the health plan/M+C organization are considered marketing materials and must therefore adhere to this *chapter* and have prior approval by CMS.

4. ***Providers/Provider Group Affiliation Information***- Providers/provider groups can announce a new affiliation with a health plan/M+C organization to their patients. An announcement to patients of a new affiliation which names only one health plan/M+C organization may occur only once. Additional contacts from providers to their patients regarding affiliation must include all the Medicare health plans/M+C organizations with which the provider contracts. This includes, for example, annual affiliation announcements, announcements that certain affiliations have terminated, and the display of health plan/M+C organization brochures/posters. If these communications describe health plans/M+C organizations in any way (as opposed to just listing them), they must be prior approved by CMS (see below).

5. ***Providers/Provider Group Comparative/Descriptive Information*** - Providers/provider groups may provide printed information to their patients comparing the benefits of different health plans/M+C organizations with which they contract. Such materials must have the concurrence of all health plans/M+C organizations involved and must be prior approved by CMS. The health plans/M+C organizations may want to determine a lead health plan/M+C organization to coordinate submission of these materials. CMS continues to hold the health plans/M+C organizations responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting medical groups and other health care providers. The providers/provider groups may not health screen when sending out such information to their patients. The reason for this is that any material sent to beneficiaries that talks about health plans/M+C organizations is marketing and health screening is a prohibited marketing activity.

6. ***Providers/Provider Group Web Sites*** - *Providers/provider groups may provide links to health plan/M+C organization enrollment applications and/or provide downloadable enrollment applications as long as the site provides the links/downloadable formats to enrollment applications for all health plans/M+C organizations with which the provider/provider group participates.*

The "**Medicare and You" Handbook** or "**Medicare Compare Information"** (from CMS' Web site, http://www.medicare.gov), may be distributed by providers/provider groups without additional approvals. There may be other documents that provide comparative/descriptive material about health plans, are of a broad nature, and are written by CMS or have been prior approved by CMS. These materials may be distributed by *health plans/*M+C organizations and providers without further CMS approval. Please advise your health plan/M+C organization providers and provider groups of the provisions of these rules.

50.3 - Specific Guidance About the Use of Independent Insurance Agents

(Rev. 28, 08-01-03)

The CMS recognizes that independent insurance agents can provide a necessary service to Medicare beneficiaries and potential enrollees. They can also be a valuable resource in helping to reach low-income and rural populations, persons with disabilities, and other special populations. Therefore, CMS urges health plans/M+C organizations to consider requiring specific cost/M+C training for their contracted agents. This will ensure that appropriate information is being delivered to Medicare beneficiaries and potential enrollees.

Please note that CMS is aware that sales by independent insurance agents are typically tied to compensation, and that agents are often given incentives to steer enrollees towards the carrier offering the most compensation. Further, independent insurance agents may be in a unique position to "cherry pick," given their often longstanding relationships with clients. Additional operational guidelines to address these concerns will be forthcoming.

50.4 - Answers to Frequently Asked Questions About Promotional Activities

(Rev. 28, 08-01-03)

1. **Q** - We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether or not they enroll in our health plan/M+C organization. Because we purchased a large number of these books, we were able to buy them at a cost of $14.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

   A - No. The retail purchase price of the book is $19.99, which exceeds CMS' definition of nominal value.

2. **Q** - We are participating in a health fair during which we will have marketing staff present. During the fair, we will offer a number of free health screening tests to people who attend. The value of these tests, if purchased, would be considerably more than $15. Is this permissible?

   A - No. You may not offer these tests for free because their value exceeds CMS' definition of **nominal** value.

3. **Q** - At our health plan/M+C organization, we offer gifts of nominal value to people who call for more information. We then offer additional gifts if they come to marketing events. Each of the gifts meets CMS' definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

A - Yes.

4. **Q** - Listed below are some possible promotional items to encourage people to attend marketing presentations. Are these types of promotions permissible?

    - Meals
    - Day trips
    - Magazine subscriptions
    - Event tickets
    - Coupon book (total value of discounts is less than $15)

    A - Yes. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are $15 or less. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount.

5. **Q** - Can a health plan/M+C organization advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $15 per person attending?

    A - No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by CMS. However, the raffle or door prize can exceed the $15 limit if the M+C organization is jointly sponsoring the prize with other health plans/M+C organizations at a health fair. See §50.1 for a discussion of rules pertaining to health fairs.

6. **Q** - What about post-enrollment promotional activities? Are there any rules prohibiting such items or activities as coupon books, discounts, event tickets, day trips, or free meals to retain enrollees?

    A - Currently, the Medicare Managed Care Manual states that health plans/M+C organizations may not offer post-enrollment promotional items that in any way compensate beneficiaries for lower utilization of services. Any promotional activities or items offered by health plans/M+C organizations, including those that will be used to encourage retention of members, must be of nominal value, must be offered to all eligible members without discrimination, and must not be in the form of cash or other monetary rebates. The same rules that apply to pre-enrollment promotional activities apply to post-enrollment promotional activities.

7. **Q** - Can health plans/M+C organizations provide incentives to current members to receive preventive care and comply with disease management protocols?

   A - Yes, as long as the incentives are:

   - Offered to current members only;
   - Not used in advertising, marketing, or promotion of the health plan/M+C organization;
   - Provided to promote the delivery of preventive care; and
   - Are not cash or monetary rebates.

   NOTE: If these products are in the CMS approved contracted health plan/M+C organization benefit package (ACR and PBP) under "Preventive Services," the provision of such incentives are within the purview of the medical management philosophy of the M+C organization and do not require additional review by CMS for marketing accuracy/compliance. The nominal value rule **does not** apply.

8. **Q** - Can a health plan/M+C organization offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the health plan/M+C organization?

   A - No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits. [18]

9. **Q** - Can a health plan/M+C organization provide discounts to beneficiaries who prepay premiums for periods in excess of 1 month?

   A - No. Health plans/M+C organizations cannot provide any discounts to Medicare beneficiaries for prepayment of premiums in excess of 1 month.

10. **Q** - Can a health plan/M+C organization take people to a casino or sponsor a bingo night at which the member's earnings may exceed the $15 nominal value fee?

    A - No. The total value of the winnings may not exceed $15 and the winnings **cannot be in cash or an item that may be readily converted to cash**.

11. **Q** - Can M+C organizations send a $1 lottery ticket as a gift to prospective members who request more information?

    A - Offering a $1 lottery ticket to prospective members violates the "no cash or equivalent" rule discussed above, whether or not the person actually wins since, generally, the "unscratched" ticket has a cash value of $1.

12. **Q** - Can *health plans/M+C organizations* pay beneficiaries that sign up to be "ambassadors" a flat fee for transportation?

    A - *The health plan/M+C organization may reimburse the beneficiary for any actual, reasonable transportation costs but must not pay the beneficiary a flat fee for transportation.* If the health plan/M+C organization employs a beneficiary to be an "ambassador" and travel reimbursement is part of the employment compensation, then CMS has no oversight over this issue.

13. **Q** - Can M+C organizations hold marketing presentations in clinics or hospitals?

    A - Yes, marketing presentations are allowed in clinics, hospitals or physicians offices (or other health care delivery locations) provided that the presentations are held in common areas (i.e., community or recreational rooms) and that patients being treated at the facility are not coerced in to attending.

14. **Q** - Can *health plans/M+C organizations* that own nursing homes conduct health fairs and distribute enrollment forms to nursing home residents?

    A - Yes, organizations that own nursing homes may conduct health fairs and distribute enrollment forms if the sales presentations are confined to a common area (i.e., community or recreational rooms) or if a member volunteered for an individual presentation. Promotional activities and sales presentations cannot be made in individual resident rooms without a prior appointment for a "home" visit. Such activities would be considered door-to-door solicitation and are prohibited. The organization is required to meet all health fair/sales presentation and enrollment requirements as currently outlined in *this chapter* and regulations.

15. **Q** - What information should an active member be asked to release to a health plan/M+C organization concerning a potential member lead?

    A - The health plan/M+C organization can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Health plans/M+C organizations can then use this information for soliciting by mail.

16. **Q** - Can physician groups that contract with health plans/M+C organizations hire marketing firms to cold call from non-health plan/M+C organization member listings?

    A - Yes, as long as the marketing guidelines for provider marketing are followed.

60 - Other Marketing Activities

(Rev. 9, 04-01-02)

60.1 - Specific Guidance about Value-Added Items and Services

(Rev. 9, 04-01-02)

Value-Added Items and Services (VAIS) are items and services offered to M+C plan enrollees, by an M+C organization, that do not meet the definition of "benefits" under the M+C program and may not be funded by Medicare program dollars. Nonetheless, VAIS may be of value to some beneficiaries, and we do not wish to deprive Medicare enrollees of access to items and services commonly available to commercial enrollees. Examples of VAIS may include, but are not limited to discounts in restaurants, stores, entertainment, and travel or discounts on health club memberships and on insurance policy premiums. The CMS permits VAIS to be offered to M+C enrollees under the rules outlined below.

The VAIS are partly defined by what they are not - they are not benefits under the M+C program. The M+C regulations at 42 CFR 422.2 define benefits using a three-prong test:

1. Health care items or services that are intended to maintain or improve the health status of enrollees;

2. The M+C organization must incur a cost or liability related to the item or service and not just an administrative cost; and

3. The item or service is submitted and approved through the Adjusted Community Rate (ACR) process.

All three parts of the definition must be met for an item or service to be considered a benefit under M+C. If an item or service fails to meet one or more of these parts, it is not a benefit. However, it may be offered to M+C enrollees as a VAIS, subject to the restrictions that follow.

The following examples demonstrate the application of the three-prong test:

Example 1:

An M+C organization arranges for its enrollees a discount on all daily supplements purchased from a health food chain. The health food chain does not charge the M+C organization for this discount, and requires the M+C organization to develop a verification system so the health food chain can identify the organization's enrollees. The M+C organization incurs an administrative cost to develop the verification system, but does not incur a cost of providing or furnishing the daily supplement. Therefore, the discount on daily supplements would be considered a VAIS. The ACR submitted by the

M+C organization may not reflect (as a Medicare enrollee benefit cost) the administrative cost.

Example 2:

An M+C organization arranges for its enrollees a 10 percent discount on eyeglasses purchased from a group of eye doctors. The physician group charges the M+C organization for the group's cost to administer the program, and requires the M+C organization to develop a verification system to identify the organization's enrollees. The M+C organization incurs two costs:

1. The M+C organization pays the physician group's administrative cost of administering the program; and

2. The M+C organization incurs the administrative cost for developing and providing the verification system.

Both of these costs are administrative in nature, and the M+C organization does not incur a cost of providing or furnishing the eyeglasses. Therefore, the discount on eyeglasses is considered a VAIS. The ACR submitted by the M+C organization should not reflect (as a Medicare enrollee benefit cost) either of the two administrative costs.

Example 2a:

Given the same circumstances outlined in Example 2 above, except, the amount paid to the physician group by the M+C organization includes an amount for the cost of the eyeglasses. In this case, the M+C organization does incur a cost of providing or furnishing the eyeglasses. Therefore, the 10 percent discount on eyeglasses is not considered a VAIS. The ACR submitted by the M+C organization should reflect the administrative costs it incurs and the amount paid to the physician group. The marketing materials should describe the eyeglass benefit with a 90 percent coinsurance. As with all benefits offered as part of an M+C plan, the Medicare enrollee must be afforded appeal rights for this benefit.

60.1.1 - Restrictions on Value-Added Items and Services

(Rev. 15, 09-27-02)

The M+C organizations may make VAIS available to Medicare enrollees in accordance with the following guidelines:

1. VAIS must be offered uniformly to all M+C plan enrollees and potential enrollees.

2. M+C organizations may not describe VAIS as benefits. In accordance with 42 CFR 422.80(e)(iv), which states that M+C organizations may not engage in

activities that could mislead or confuse Medicare beneficiaries, the M+C organization may not claim or imply that the VAIS are recommended by or endorsed by CMS or Medicare.

3. The M+C organization must maintain confidentiality of enrollee records in accordance with 42 CFR 422.118 and other applicable statutes and regulations. The use or distribution of information about enrollees for non-plan purposes is prohibited. The M+C organization is thus prohibited from selling names, addresses, or information about the individual enrollees for commercial purposes. If the M+C organization uses a third party to administer VAIS, the M+C organization is ultimately responsible for adhering to and complying with confidentiality requirements.

60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations

(Rev. 20, 04-04-03)

Health plans/M+C organizations can market, either through oral presentations or written materials, Value-Added Items and Services (VAIS). Organizations can also mention VAIS in their newsletters. VAIS may not appear in the Plan Benefit Package (PBP) or the Standardized Summary of Benefits (SB) (including in the M+C organization special features §30 at the end). However, organizations will be permitted to reference their pharmacy discount program in section 3 of their SB, provided they also include the disclaimers included in this section. In addition, the SB must clearly state (in the location that the program is described) that the discount drug program will be available for the entire contract year.

Any description of VAIS must be preceded by the following prominently displayed language:

1. The products and services described on this page are neither offered nor guaranteed under the M+C organization's contract with the Medicare program, but are made available to all enrollees who are members of [Name of *plan*].

2. These products and services are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the [Name of *plan*] grievance process.

3. Should a problem arise with any Value-Added Item or Service, call [Name of *plan*] for assistance at [*Customer service number*]. Our customer service hours are [Enter hours].

VAIS must not appear in the Plan Benefit Package (PBP) or the Standardized SB (including in the health plan/M+C organization special features §30 at the end). However, organizations will be permitted to reference their pharmacy discount program

in section 3 of their SB, provided they also include the disclaimers included in this section. In addition, the SB must clearly state (in the location that the program is described) that the discount drug program will be available for the entire contract year.

Organizations may include VAIS along with their ANOC and*/or* SB in one bound brochure as long as the value-added services are clearly distinct from the ANOC and*/or* SB (such as on a different color piece of paper), and the information on value-added services includes all the disclaimers required in this chapter.

Because VAIS does not meet the definition of a benefit under the M+C program, neither the actual costs of the VAIS nor associated administrative costs may appear in the ACR. Furthermore, because they are not contained within the contracted health benefits package, these services are not subject to the Medicare appeals process. VAIS may not be described in Medicare Compare or the "Medicare and You" handbook.

The CMS will not require prior approval of materials describing VAIS, since VAIS are not benefits as described within CMS regulations. The CMS will review these materials on monitoring visits to ensure compliance with these requirements. The CMS may initiate a monitoring visit if it becomes aware that materials have been distributed describing VAIS without the appropriate disclaimers or in violation of the requirements stated herein. CMS will also investigate complaints by beneficiaries regarding VAIS, just as it would other possible violations of CMS requirements.

60.1.3 - Value Added Items and Services Provided to Employer Groups

(Rev. 9, 04-01-02)

Value-added items and services may be offered to employer groups. Value-added items and services are offered outside the core benefit package, thus they are outside of CMS' purview.

60.1.4 - Application to §1876 of the Social Security Act (the Act) Cost Plans

(Rev. 9, 04-01-02)

Value-added items and services may be offered by §1876 cost plans. However, VAIS are non-covered services for which §1876 cost plans are not reimbursed

60.2 - Marketing of Multiple Lines of Business

(Rev. 28, 08-01-03)

M+C organizations may market multiple lines of business in accordance with the following.

Direct mail: Direct mail *health plan/M+C organization* marketing materials sent to current members describing other lines of business should contain instructions describing how individuals may opt out of receiving such communications. *Health plan/M+C organizations* may apply this opt-out provision on an annual basis. *Health plan/M+C organizations* should make reasonable efforts to ensure that all individuals (including non-members) who ask to opt out of receiving future marketing communications, are not sent such communications.

NOTE: *These instructions regarding "opting out" of receipt of direct mail apply only to information that does not require prior authorization, as discussed in §60.2.1.*

With one exception (mentioned below), *health plans/M+C organizations* may advertise multiple lines of business in direct mail marketing materials within the same document as the one that is advertising the *plan* product, as long as the non-*plan* lines of business are clearly and understandably distinct from the *plan* product. For example, the document might highlight the name of the plan product in bold and underlined font and then include a paragraph to describe the product in "regular" font, then it would go on to highlight the name of a Medigap product in bold and underlined font followed by a paragraph describing the Medigap product in "regular" font. Please keep in mind that the direct mail materials advertising multiple lines of business still should allow the beneficiary the choice of opting out of receiving future notices about non-M+C products. Also, if a *health plan/M+C organization* advertises non-*plan* products with a *plan* product, it must pro-rate any costs so that costs of marketing non-*plan* products are not included as "plan-related" costs on Adjusted Community Rate (ACR) proposal submissions.

Organizations that offer more than one type of Medicare+Choice products (HMOs, PPOs) may market all of the products as a "family of products." In this case, the marketing materials must clearly distinguish between the type of product, eligibility requirements, how to obtain services (lock-in, preferred vs. non-preferred benefits), and any out-of-pocket maximums, and specify the benefits to which they apply. Furthermore, multiple product advertising may only be conducted in areas where those products share service areas. We recognize that service areas may not perfectly align. When this occurs, the M+C organization should make a reasonable effort to market the "family of products" only in counties that all products share.

Direct Mail **Exception**

While *health plans/M+C organizations* may mention non-*plan* lines of business at the time they send a plan nonrenewal notice, they may only do so using separate enclosures in the same envelope. *Health plans*/M+C organizations *must* not include mention of the non-*plan* lines of business within the actual nonrenewal notice. The purpose of this exception is to ensure that the nonrenewal notice gives beneficiaries focused information only about the *plan* nonrenewal.

Health plans/M+C organizations must not include enrollment *applications* for non-*plan* lines of business in any package marketing its M+C products, as beneficiaries might

mistakenly enroll in the other option thinking they are enrolling in a *health plan/M+C organization*. Also, if information regarding *cost*/M+C products and non-plan lines of business are included in the same package, postage costs must be prorated so that costs of marketing non-*plan* products are not included as "plan-related" costs on ACR proposal submissions.

Television: Health plans/M+C organizations may market other lines of business concurrently with plan products on television advertisements, as long as those products are separate and distinct from the plan product.

Internet: Health plan/M+C organizations may market other lines of business concurrently with *plan* products on the Internet, though to avoid beneficiary confusion, *the health plan/M+C organization* must continue to maintain a separate and distinct section of their Web site for plan information only.

The CMS will review the M+C organization's Web pages to ensure that M+C organizations are maintaining the separation between M+C plan information and information on other lines of business.

60.2.1 - HIPAA and the Marketing of Multiple Lines of Business

(Rev. 20, 04-04-03)

In general, a health plan/M+C organization does not need to obtain authorization from beneficiaries to market its own health-related, value-added products. This includes other lines of business offered by the same covered entity and its subcontractors (business associates) doing business on behalf of the covered entity. However, a health plan/M+C organization must obtain authorization from beneficiaries under certain circumstances. For example, authorization is needed if the product is a pass-through discount, a product offered by an entity other than the covered entity or outside of a business associate contract, an accident only policy, a life insurance policy, or is not in the plan of benefits because it is not a health related item or service. For additional information regarding HIPAA, go to http://www.hhs.gov/ocr/hipaa/.

60.3 - Third Party Marketing Materials

(Rev. 20, 04-04-03)

From time to time, a third party may prepare marketing materials for a health plan's/M+C organization's membership and/or supply those materials to the membership. These materials are known as "third party marketing materials," and can be prepared both by benefit/service providing and non-benefit/service providing third parties. Marketing review of these materials is dependent upon the type of third party, as outlined in the remainder of this section.

60.3.1 - Benefit Providing Third Party Marketing Materials

(Rev. 20, 04-04-03)

A benefit/service-providing third party is an entity that either administers or covers the health care benefits of the health plan's/M+C organization's Medicare membership or provides health care services to the health plan's/M+C organization's Medicare membership. Some examples of benefit/service-providing third party entities would be employer groups, drug companies, or nursing homes, etc.

Other than M+C employer group marketing materials, CMS reviews all marketing materials prepared by benefit/service-providing third party entities if they will be used by the health plan/M+C organization for its membership (as stated in §20.2, M+C organizations are waived from having marketing materials reviewed for employer group members). Marketing materials must be submitted to CMS via the health plan using the materials, and may not be submitted directly by the third party to CMS. The benefit/service-providing third party should submit the material via the health plan/M+C organization with the largest membership.

*In the event a benefit/service providing third party works with multiple health plans to provide the **same** marketing material to each organization's membership, the material need only be approved by CMS once, as long as that material is not for use by health plans/M+C organizations with dual eligible members (since dual eligible marketing materials may need to vary by state). Once CMS has approved the material, it is considered approved for all other health plans/M+C organizations with which the third party works. The third party or the health plan/M+C organization may change the product name, telephone numbers, addresses, and/or tracking codes on the material and a new approval will not be necessary.*

Please note that as part of its business relationship with other health plans/M+C organizations the third party must inform the other health plan/M+C organization that it would like to use the CMS-approved material for its membership. Also, the health plan/M+C organization and the third party should work together to determine whether the material will be used for the health plan's membership or whether new materials need to be developed.

If a health plan/M+C organization intends to have the third party provide the pre-approved material to its membership, it must send an "FYI" copy of that material to the Regional Office (RO) for the RO files.

The CMS does not review marketing materials originated by non-benefit providing third party entities. For the purpose of marketing review, non-benefit providing third party entities are defined as any organizations or individuals that supply information to an M+C organization's membership which is paid for by the M+C organization or by themselves. An example of a non-benefit providing third party would be a managed care research firm that provides managed care data relating to managed care organizations.

If a non-benefit providing third party wishes to market to M+C membership, they must submit their materials to the M+C organization, who in turn, can distribute the materials to their membership. It is the responsibility of the M+C organization to ensure that all non-benefit providing third party marketing materials contain the disclaimer, "Medicare has neither reviewed, nor endorses this information." This disclaimer must be prominently displayed at the bottom center of the first page of the material and must be of the same font size and style as the commercial message.

60.3.2 - Non-Benefit/Service Providing Third Party Marketing Materials

(Rev. 20, 04-04-03)

A non-benefit/service providing third party is an entity that neither administers the health care benefit nor provides health care services to the health plan's/M+C organization's Medicare membership. For the purpose of marketing review, non-benefit/service providing third party entities are organizations or individuals that supply information to a health plan's/M+C organization's membership which is paid for by the health plan/M+C organization or by themselves. An example of a non-benefit/service providing third party could be a research firm that provides comparative data relating to managed care organizations.

The CMS does not review marketing materials originated by non-benefit providing third party entities.

If a non-benefit*/service* providing third party wishes to market to *health plan/M+C organization*, membership, they must submit their materials to the *health plan/M+C organization, which* in turn, can distribute the materials to their membership. It is the responsibility of the *health plan/M+C organization* to ensure that *these* marketing materials contain the disclaimer, "Medicare has neither reviewed, nor endorses this information." This disclaimer must be prominently displayed at the bottom center of the first page of the material and must be of the same font size and style as the commercial message.

60.4 - Marketing Material Requirements for Non-English Speaking Populations (QISMC Standard 2.3.3.2)

(Rev. 11, 08-15-02)

Health plans/M+C organizations should make marketing materials available in any language that is the primary language of more than 10 percent of the geographic area. In addition, basic enrollee information should be made available to the visually impaired.

Endnotes

(Rev. 28, 08-01-03)

[1] The primary CMS/health plan contractual frame of reference in *Chapter 3* is *of a Medicare+Choice organization offering a* coordinated care plan. Where applicable, alternative language is provided for cost *plans* as well as scenarios involving the point-of-service (POS) and Visitor Program features which may be applicable for M+C an/or cost *plans*.

[2] The guidelines throughout this document apply to Medicare + Choice Organizations (M+C organizations) as well as Section 1876 of the Act cost contractors unless stated otherwise. Therefore, for ease of review and reference, the term "health plan" is used throughout the document to include requirements specific to both Medicare + Choice Organizations and §1876 cost contractors.

[3] See §30 of the chapter for specific application requirements for Outdoor Advertising (ODA.).

[4] Under M + C, individuals who are not already member - those that are grandfathered in - must have both Parts A and B of Medicare in order to eligible for enrollment.

[5] The health plan/M+C organization must be sure to offer adequate explanation of Medicare card use with out-of-plan utilization that is not an emergency or an urgently-needed service.

[6] Note to health plan/M+C organization - CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in health plan/M+C organization operations.

[7] Note to health plan/M+C organization - A member of the health plan/M+C organization may use a superlative in relating their personal experience with the health plan/M+C organization so long as the testimonial is preceded with the phrase "in my opinion" (e.g., "I have been with the health plan/M+C organization for 10 years and in my opinion they have given me the best care possible.") If the member does not preface the superlative statement with the "in my opinion" phrase, the member must substantiate the statement with an acceptable qualifying information source.

Note 8 has been deleted.

[9] In accordance with *Chapter 3*, this information should be provided in at least 12-point font size.

[10] The M+C organizations may choose to disseminate an errata sheet or addendum during the year to update members with respect to changes in provider's addresses and phone numbers. However, in accordance with 42 CFR 422.111(c), M+C organizations must

make a good faith effort to disclose any changes to the provider information upon request and, under 422.111(e), must make a good faith effort to provide written notice at least 30 calendar days before the termination effective date. M+C organizations should consult the M+C regulations for further information.

[11] In accordance with *Chapter 3*, the applicable TDD/TTY number must also be provided, including the hours of operation.

[12] The CMS' monthly capitation rate to an M+C organization for a plan member is higher for an enrollee who is a Medicaid recipient because, statistically, the Organization incurs higher medical costs due to higher utilization than that of a non-Medicaid recipient. However, *because CMS created the QI-1 category of Medicaid recipients after it established the standard monthly payment upon which it bases all capitation payments,* CMS *policy is to* not pay the Medicaid adjustment factor for *this group*.

[13] *Since health plans/M+C organizations are primarily responsible for conducting outreach, Chapter 3 has been written targeting that audience.* However, if the *health plan/M+C organization* contracts with another entity for any part of this outreach, the contracting entity must abide by *Chapter 3* as well.

[14] The CMS considers the following to be examples of substantive changes to an outreach program that would make the proposal and/or attached member materials an "initial" proposal: changes to the steps involved in the outreach process, changes to the language in the outreach letters, revisions to the telephone scripts, changes to the network of subcontractors participating in the outreach efforts, etc. CMS considers the following to be examples of changes allowable without designating the proposal as "initial": contact telephone numbers, letterhead, mailing dates and targeted member numbers, updates to income and resource criteria and benefit levels as updated by the State.

[15] *Outreach proposals should go to the PCT Lead, Ann Knievel, CMS San Francisco Regional Office, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105; phone: 415-744-3625; fax:415-744-3761; Aknievel@cms.hhs.gov.*

[16] Section 1851(e)(3) of the Act and 42 CFR 422.10(b).

[17] An *application form* may be either:

1. A specifically designed enrollment application form which is attached to health plan/M+C organization marketing materials; or

2. A standard health plan/M+C organization enrollment application form with instructions that the form must be mailed back to the health plan M+C organization.

The key feature of the *application form* is that it must be completed by the beneficiary in the absence of health plan/M+C organization marketing influences and returned to the

health plan/M+C organization by mail. (Self-addressed, postage paid, return envelopes may be provided by the health plan/M+C organization.).

[18] This "no" statement also applies to "zero" premium plans that might want to award a nominal value gift as a reward for longevity of enrollment.